Working 'upstream' to reduce health inequalities: A Foucauldian discourse analysis

by

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ABSTRACT

There has been a long-standing concern to reduce health inequalities between different social groups. While primarily understood as arising from the inequitable distribution of power, wealth, and resources, in recent years dominant scientific and political discourses have resulted in health inequalities being understood as a problem of individual behaviour. In response, a number of counter-discourses have emerged which seek to reorient efforts away from tackling these symptoms of the problem, to work once again at the level of root causes. In this thesis, I conduct an in-depth analysis of one of these counter-discourses, the upstream parable, to examine how it operates in research and practice. Employing a form of discourse analysis underpinned by the ideas of Michel Foucault, I examine how the idea of working 'upstream' is articulated in a sample of peer-reviewed articles, and how it is interpreted by a sample of people working to reduce health inequalities in the North West of England. I demonstrate that there are many different ways of constructing the problem of health inequalities, and that the upstream counter-discourse, rather than resulting in a reframing of the problem, is in fact interpreted in light of existing perspectives. This finding illustrates the malleability of the discourse, and serves to challenge the extent to which it can operate to successfully reframe the problem of health inequalities, and reorient efforts to work at root causes. In this thesis, I make an original contribution to knowledge by going beyond a critique of dominant perspectives to provide original insights about how an established counter-discourse, in the field of health inequalities, operates in practice. I identify shortcomings of the discourse, and make recommendations for how ideas which appear in the academic literature, could be employed more fruitfully in practice to reorient efforts to work at the root causes of this intractable problem.

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ABBREVIATIONS

BUMP	Butterfield Upstream Model for Population Health
DHSS	Department of Health and Social Services
ED	Emergency Department
FDA	Foucauldian discourse analysis
GP	General Practitioner
GRO	General Register Office
HCP	Healthcare Professional
HIAT	Health Inequalities Assessment Toolkit
IGIs	Intervention generated inequalities
INFORMAS	International Network for Food and Obesity/non-communicable diseases Research, Monitoring and Action Support
MECC	Making Every Contact Count
NIHR	National Institute for Health Research
NHS	National Health Service
PHU	Public Health Unit
PPI	Patient and Public Involvement
SDH/SDOH	Social determinants of health
UK	United Kingdom
US	United States
WHO	World Health Organisation

INTRODUCTION

Health differences across social groups have been a long-standing concern for both the state, and those with a responsibility for promoting and maintaining the health of populations. In recent years, these health differences have become known as 'health inequalities', and academics, practitioners, and policy makers are increasingly tasked to reduce them. However, there is much debate as to how best to reduce these health inequalities, and it has been suggested that for too long efforts have been limited to "tinkering" around the edges of what is a major social and economic problem (McKinlay, 1979, p. 583). In response to this tendency, there is an ongoing call to reorient efforts 'upstream' and work at the root causes of the problem. In this thesis, I examine in-depth this idea of working 'upstream' to reduce health inequalities.

The purpose of this Introduction is to contextualise the work and present the rationale for the research questions and the approach taken. I first provide an account of the ongoing debates around the drivers of health inequalities, and introduce the pervasive problem of 'lifestyle drift'. The setting in which the research takes place is next described, before detailing the research questions. I then briefly outline the methodological approach employed to answer the study questions, and provide an overview of the thesis chapters.

Background

To illustrate the debates which have dominated in the United Kingdom (UK) since the late 1970s, I have structured this account into three sections. I first detail the explanations for health inequalities put forward in the landmark *Black Report* (DHSS, 1980), and discuss some of the legacy effects of these explanations. I then detail the polarised and politicised nature of debates which took place in response to the development of psychosocial explanations for health inequalities made popular at the turn of the century. In the final section, I introduce the problem of 'lifestyle drift', which has dominated discussions in recent years, and I detail the associated calls to reorient efforts 'upstream' which have been so influential in shaping the research questions for the thesis.

The legacy of the Black Report's four explanations

In 1980, the landmark *Black Report* was published, which proposed four possible explanations for health inequalities (DHSS, 1980). Due to the politically charged context into which the report was published, commissioned by a Labour government and presented to a new-to-office Conservative government, one of the primary legacies of the report is said to be the polarisation of debate around the drivers of health inequalities. This polarisation of debate continues today, and so it is important to put in context the concerns of commentators at this time, and explain their rationale for treating differing explanations as mutually exclusive, and indeed at times oppositional.

Within the report, the four explanations discussed were: (i) artefact, (ii) selection, (iii) cultural/behavioural, and (iv) materialist/structural. The artefact explanation suggests that health inequalities do not exist, and that they can be explained away by data collection methods. Natural/social selection suggests an inverse causal link between social position and health, whereby health determines one's position in the social hierarchy. Individuals of poorer health are less upwardly mobile and as a result are concentrated in the lower social class groups. Cultural/behavioural explanations attribute health inequalities to differences in risk behaviours (e.g. smoking, poor diet, alcohol, sedentary behaviour), which are deemed to be more prevalent amongst the lower social classes. Behaviours related to access and uptake of health services, including the use of preventative health services, are also included in this explanation. Finally, materialist/structural explanations look beyond individual level factors to consider the effects of material and psychosocial conditions related to social position on health. In particular, this explanation focuses on income inequality which limits access to necessary goods and services, while increasing exposure to physical and psychosocial risks.

To explain how these explanations came to be treated as mutually exclusive, Macintyre (1997) proposed that a distinction be made between 'hard' and 'soft' versions (Table 1). The purpose of developing these distinctions was to bring to light some confusion or misinterpretation of the explanations as they appeared within the report. For example, it is often implied that the report rejected all versions of explanations except for the 'hard' version of the materialist/structural explanation, which as shown in Table 1 suggests that income inequality and the associated material disadvantage for lower social class groups is the single most convincing explanation for health inequalities. However, using excerpts from the report itself,

Macintyre (1997) provides evidence to suggest that actually the report rejected only the 'hard' versions of artefact, selection, and cultural/behavioural explanations, and actually supported the 'soft' version of the materialist/structural explanation.

Table 1. The two versions of the *Black Report* explanations (Macintyre, 1997)

Explanation	'Hard' version	'Soft' version
Artefact	No relation between class and mortality; purely an artefact of measurement	Magnitude of observed class gradients will depend on the measurement of both class and health
Natural/ social selection	Health determines class position, therefore class gradients are morally neutral and explained 'away'	Health can contribute to achieved class position and help to explain observed gradients
Materialist/ structural	Material, physical conditions of life associated with the class structure are the complete explanation for class gradients in health	Physical and psychosocial features associated with the class structure influence health and contribute to observed gradients
Cultural/ behavioural	Health damaging behaviours freely chosen by individuals in different social classes explain away social class gradients	Health damaging behaviours are differentially distributed across social classes and contribute to observed gradients

In light of this finding that the report did not reject the 'soft' explanations of artefact, selection, and cultural/behavioural explanations, Macintyre (1997, p. 731) theorised that it was the political context at the time which resulted in polarised interpretations of the report. For example, she explains the concern that any apparent support for the 'soft' versions of these explanations could be mistaken as support for the 'hard' versions. As such, with a government committed to reduced public spending, and all too ready to support explanations that would alleviate the need to take action on health inequalities, there was a reluctance to draw attention to anything beyond the 'hard' versions of the materialist/structural explanation. The years that followed were thus taken up with research reports focused on refuting the alternatives, and treating, in particular, cultural/behavioural explanations as antithetical to the agenda of reducing health inequalities (for example Blane, Smith, & Bartley, 1993; Davey Smith, Bartley, & Blane, 1990; Smith, Blane, & Bartley, 1994). The polarised nature of the health inequalities debate evident at this time would continue, and indeed would become heightened during a later period of explicit government support for the health inequalities agenda.

The social gradient and psychosocial explanations

One of the most notable developments at the turn of the century was the attention being paid to the now established social gradient in health, and theories to explain what it was about *relative* income, as opposed to *absolute* income, that proved so influential in shaping health outcomes. While the social gradient had long been of interest to social epidemiologists, it was the work of Michael Marmot and Richard Wilkinson around this time which resulted in new explanatory theories being introduced into the health inequalities debate (Marmot et al., 1991; Wilkinson, 1996). These theories emphasised the role of psychosocial factors in mediating the relationship between income inequality and health inequalities. Interestingly, despite the now more conducive political context due to the election of a Labour government committed to reducing health inequalities, proposals espousing a role for psychosocial factors were again seen as a potential threat to achieving more radical policy action to address income inequality.

The idea of 'social capital' was one particular manifestation of these psychosocial theories, which prompted much debate between commentators who aligned to a greater or lesser extent with the 'hard' version of the *Black Report*'s materialist/structural explanation. Concerns around the value and utility of the concept of social capital related primarily to the conceptualisations employed by the authors. For example, two distinct approaches to social capital have been identified within the literature, where the first focuses on horizontal social interactions and notions of 'community spirit' (Whitehead & Diderichsen, 2001). This perspective is closely aligned to the work of Putnam (2000), with the resulting policy implications said to be limited to actions to increase "general levels of associational activity and civic engagement" (Bridgen, 2006, p. 31). It is this perspective which has been shown to dominate in the public health literature (Moore, Haines, Hawe, & Shiell, 2006; Muntaner, Lynch, & Smith, 2001). In contrast is the approach to social capital that has its origins in the work of Pierre Bourdieu. Bourdieu (1986) emphasises the distribution of social resources through networks of relationships, and how the inequitable distribution of, and access to such resources operates to continuously reproduce social inequality, and as a consequence economic and health inequalities. Szreter and Woolcock (2004, p. 654) provide a useful analogy to distinguish the two perspectives, whereby the former accounts for network infrastructure alone (i.e. the 'wires'), whereas the latter accommodates and encourages analysis of the 'topography' of the land itself, to describe how the network infrastructure has come

to be distributed through society, and indeed to consider the nature of the resources that flow through such networks (i.e. the 'electricity').

These contrasting perspectives reflect the core of the debate at this time, which considered whether changes in social capital itself were independently contributing to health outcomes, or if changes in social capital were reflective of broader changes in income inequality (Szreter & Woolcock, 2004). Commentators who ascribed primacy to income inequality expressed concern about the potential for social capital to be seen as a more easily modifiable mechanism that could be fixed "on the cheap" through policy actions which focused on, for example, the development of social support networks (Szreter & Woolcock, 2004, p. 652). Indeed Muntaner et al. (2001, p. 225) suggested that such an approach could result in a "retreat" from the pursuit of policy action to address structural inequalities, and the legitimisation of "mass psychotherapy for the poor to change their perceptions of place in the social hierarchy". To avoid this drift towards more easily modifiable mechanisms, these authors suggest that greater attention be directed towards understanding the causes of income inequality itself, which are considered to be more modifiable than is often perceived (Coburn, 2000; Lynch, 2000). Proponents of psychosocial explanations however dismissed these concerns, and suggested that, by illustrating the relationship between income inequality and psychosocial factors. they were building *more*, and not less of a case for tackling social issues through reducing income inequality (Wilkinson & Pickett, 2015).

One final point to make about the debate during this period, was the contribution of sociologists, who were critical of the disciplinary dominance of epidemiology and the emerging "false dichotomy" between material and psychosocial explanations (Moore et al., 2006, p. 733). Popay, Williams, Thomas, and Gatrell (1998) argued for example, that the tendency of epidemiological approaches to treat psychosocial factors (e.g. social relationships) as risk factors, failed to link structure and agency, and thus failed to account for the complexity of causal explanations for health inequalities. Scambler and Higgs (2001, p. 157) provide a different perspective, highlighting the lack of "a more creative and robust theorization of class", which they view as a fundamental component in explaining "enduring health inequalities". However, despite the diverse contributions to the debate, it was indeed a relational and interactionist view of psychosocial factors which was found to gain most traction in policy circles at this time, and so the succeeding years were once again dedicated to challenging this "slippage" away from action on the material determinants of

health inequalities (Graham, 2009a, p. 471), and thus calling for efforts to be reoriented 'upstream'.

An unshakeable drift in theory and practice

Debates surrounding the drivers of health inequalities have thus been characterised by polarised dichotomies (i.e. material-behavioural, material-psychosocial) which have sought to keep in the frame the role of fundamental economic inequality in shaping health inequalities. However, despite these efforts, there has been a consistent tendency to address more easily measurable and modifiable phenomena. The phrase "lifestyle drift" was coined to describe this tendency to start off with the intention of taking action on the material determinants of health inequalities, but ultimately engaging in action that is largely oriented around changing individual level factors such as lifestyle behaviours (Popay, Whitehead, & Hunter, 2010, p. 148). This 'lifestyle drift' also tends to be coupled with a move away from conceptualising health inequalities in terms of a social gradient, to focusing on targeted action amongst the poorest groups in society (Whitehead, 2012). The culmination of these shifts in focus is a retreat away from radical social change to the pursuit of "low-lying fruit" and "quick fixes" (Popay et al., 2010, p. 148)

Despite the attention paid to the role of inequalities in power, wealth, and resources in the most recent report by Marmot et al. (2010), concerns about 'lifestyle drift' remain. As Marmot himself has been a longstanding proponent of psychosocial explanations, the attention given in this report to factors such as isolation, sense of control, and individual and community empowerment was said to be unsurprising (Bambra, Smith, Garthwaite, Joyce, & Hunter, 2011). However, it is again this attention to psychosocial factors which has been most heavily critiqued for its potential to legitimise inaction on material inequality in favour of targeted action to build individual "capabilities" (Pickett & Dorling, 2010, p. 1233). Indeed, some authors have cautioned that if, in the future, we are to avoid continued rehashing of the same debates, what is needed is a "a radical shift in thinking and in actions" that moves beyond "nonmaterial incarnations of inequality" to work at their root causes (Bambra et al., 2011, p. 403). The upstream parable represents one manifestation of this radical shift in thinking. While the language of the upstream parable has traditionally been used to describe or label determinants of health, it has in recent years evolved "from parable to concept, noun to adjective, and ideal to strategy" (Butterfield, 2017, p. 3). However, while there exists an extensive body of literature detailing and theorising the 'upstream' drivers of health inequalities, there remains

a gap in our knowledge about how the upstream parable operates to mobilise thinking and action to work at the root causes of health inequalities. This thesis aims to generate new insights that can contribute to closing this gap.

Motivation for the research, research setting, and aims

It is important to highlight at the outset of the thesis that I did not set out with the explicit intention of conducting an in-depth analysis of the upstream parable. Rather, the research questions resulted from the intersection of three things: (i) my early reading around theories and debates in the field of health inequalities (set out in the previous section), (ii) my own professional background as a clinician having first trained as a physiotherapist, and (iii) the setting and funding body for the research which was a local health research collaboration grappling with this challenge of working to reduce health inequalities. It was as a consequence of these experiences that I became increasingly drawn to the upstream parable, how it *was* being used, and indeed how it *could* be used, to articulate more ambitious ways of working to reduce health inequalities.

While I had encountered the upstream parable during my clinical training, it was solely used in the context of describing preventative action, whereby any action or intervention which went beyond treatment and cure would be reflective of working 'upstream'. Additionally, I understood the parable only in terms of prevention at the level of the individual (e.g. lifestyle advice), without ever being challenged to think, in a more structural way, about how different behaviours or risk exposures had come to be so unevenly distributed through our societies. Indeed, it is now evident to me that I brought to this research rather limited insights. As a consequence, the research itself was an exercise in challenging my own engrained perspectives to acquire a more developed and robust lens through which I could understand the complex problem of health inequalities.

Importantly, I found that this tension of negotiating one's own clinically driven perspectives and the mandate for action on a socially driven problem was reflected in early debates and discussions across the health research collaboration. The collaboration was made up of people from higher education institutions, National Health Service (NHS) settings, local government partners, and third sector organisations, all with an interest and mandate to reduce health inequalities. A Public Reference Panel was also established from the outset which acted to embed Patient and Public Involvement (PPI) across all funded activities. When attending

engagement events held by the collaboration, it often seemed to me that tensions arose because people were coming at the problem of health inequalities from very different professional backgrounds, perspectives, and work settings. As a consequence, they were often discussing very different problems, while also lacking a shared language or framework through which the relative contribution of different groups to reducing health inequalities could be better articulated and understood. Additionally, it was my sense that while people were generally open-minded as to how we could come at the problem of health inequalities in different and indeed more ambitious ways, there was not a clear articulation of what this might look like, particularly for professionals and groups who very often were situated in local settings working directly with patients and the public.

These early experiences were highly influential in shaping the research questions for the thesis, and I was motivated in particular to come at the research with a focus on action. Thus, the aim of the research was to unpack and synthesise what it may mean to work 'upstream' and contribute to tackling the root causes of health inequalities.

And so in the thesis I set out to answer two questions:

1. How is the idea of working 'upstream' articulated in the academic literature?
2. How is the upstream parable interpreted by a sample of people working to reduce health inequalities?

Overview of the approach and thesis structure

After some trial and error, I came to treat the upstream parable as a counter-discourse in the field of health inequalities. In order to answer the research questions, I employed a variant of discourse analysis underpinned by the work and ideas of French historian and philosopher Michel Foucault. This particular approach provides a robust analytic lens through which one can examine the ways in which problems come to be constructed through discourse, and to examine the ways in which discourses operate to powerfully influence thinking and action on particular versions of problems. I employed a six-step approach to Foucauldian discourse analysis (FDA), and applied the framework to two datasets: (1) a sample of academic texts which employed the language of the upstream parable to describe actions to reduce health inequalities, and (2) a sample of semi-structured interviews with researchers, practitioners, and public advisors actively involved in work to reduce health inequalities in the North West.

As the concepts and ideas of Michel Foucault have been so influential in shaping the nature of the questions asked, and in providing an analytic lens which underpins the entire thesis, I have dedicated **Chapter 1** to providing an account of the Foucauldian Framework employed in this work. An essential part of a Foucauldian approach to inquiry is the use of a historical lens to understand how discourses operate over time to shape the ways in which problems come to be constructed, and thus shape thinking and action. **Chapter 2** therefore provides a historical account of the problem of health inequalities, and the highly influential discourses to which the upstream parable emerged as a direct response. While theoretical developments in recent years have been outlined above, this account provides a more detailed examination of the historical evolution of the problem, and in particular seeks to describe the conditions which gave rise to the emergence of the upstream parable. The upstream parable is just one manifestation of the call to reorient efforts away problem-specific tinkering, and so, in **Chapter 3**, I synthesise empirical research which has also sought to examine the ways in which different counter-discourses operate to shape thinking and action on the problem of health inequalities. Most importantly this chapter draws attention to some potential shortcomings in the existing evidence base which may be fruitfully addressed through the approach employed in this thesis.

I provide a detailed account of the methodological approach employed in the thesis in **Chapter 4**. I situate the work of Michel Foucault presented earlier in the thesis in context, and illustrate the ways in which Foucault's work reflects developments in wider intellectual movements in the 1960s and 1970s. I outline the steps taken in constructing both datasets for the study and the application of the Foucauldian discourse analytic framework, before attending to some of the challenges and limitations of the approach.

I present the study findings in **Chapters 5, 6,** and **7**. In **Chapter 5** I answer the first research question for the thesis, presenting an academic account of the upstream counter-discourse based on my discourse analysis of peer-reviewed literature. The second study question is addressed in **Chapter 6** and **Chapter 7**, where I detail how a sample of researchers, practitioners, and public advisors interpret the upstream parable in the context of reducing health inequalities. **Chapter 6** focuses on presenting participants' interpretations of the parable, while **Chapter 7** provides an account of the process work which participants see as needed in order to actualise their interpretations of the parable. While the analyses of the two datasets are presented separately in the findings chapters (**5**, **6**, and **7**), they are discussed together

in **Chapter 8** where I summarise the main findings of the study, and put forward some possible explanations for convergences and divergences across the two datasets. In this final chapter I also outline the implications of the study findings for policy, practice, and future related research.

A note on the use of 'health inequalities'

There has been much debate as to which term best captures the unjust nature of the health differences that exist between social groups. For example, 'inequality' has been suggested to be too generic a term, and too often used to describe natural or expected variations in health outcomes (e.g. declining health in older adults). To explicitly highlight the unfair and unjust nature of these health differences, the term 'inequity' was proposed to better capture a sense of social injustice (Kawachi, Subramanian, & Almeida-Filho, 2002, p. 647) . However, in many countries the terms 'inequality' and 'inequity' mean the same when translated (Whitehead & Dahlgren, 2006, p. 4), and in the UK, it has been the phrase 'health inequalities' that has prevailed. 'Health inequalities' then are defined as variations or differences in health that are "systematic, socially produced (and therefore modifiable) and unfair" (Whitehead & Dahlgren, 2006, p. 2). Traditionally, health inequalities have been synonymous with socioeconomic inequalities in health (Graham, 2004b). However, other facets of social position, and their potential to interact and contribute to accumulating disadvantage, are increasingly recognised for their role in contributing to health inequalities (Graham, 2009b). Such inequalities are sometimes explicitly referred to as, for example, 'gender inequalities in health' or 'ethnic inequalities in health', as distinct from 'socioeconomic inequalities in health'. However, 'health inequalities' is increasingly used as an umbrella term in the UK, and is the phrase which has been employed by the research collaboration funding this research. As such, I have opted to use this phrasing throughout the thesis.

A note on the use of inverted commas

Throughout the thesis single inverted commas are used to denote discipline-specific terminology e.g. 'upstream', 'lifestyle drift'. Double inverted commas ("…") are used to indicate direct quotes.

CHAPTER 1: A FOUCAULDIAN FRAMEWORK

As outlined in the Introduction, the perspective for the thesis is informed by the work and ideas of French historian and philosopher Michel Foucault (1926–1984). I have found Foucault's work incredibly helpful in both refining the research questions for the study, and in providing a novel analytic frame through which I could make sense of the broad and complex health inequalities literature. The purpose of this chapter is to outline seminal concepts from Foucault's work which underpin the perspective employed in tracing the historical evolution of the problem of health inequalities (Chapter 2), and which underpin the methodological approach employed in the thesis. In the opening sections of this chapter I first describe what Foucault set out to achieve through his work, and his characteristic historical approach to inquiry. The main body of the chapter is dedicated to detailing his concepts of discourse, power, and power-knowledge, and illustrating how these concepts relate together and form a Foucauldian framework. While some aspects of the content relate to health inequalities, the chapter itself is intended to act primarily as an account of how some of Foucault's most notable ideas have been employed in the thesis. Of particular importance is the focus on *problems* and the role of discourse in shaping knowledge and action.

1.1.Foucault's project

Foucault was interested in bringing to light how, at different points in time, different ways of looking at and understanding the world shaped our knowledge of problems and, as a consequence, our actions. He described these ways of knowing the world as systems of thought or "epistemes" (Foucault, 1970, p. xxiii). Foucault's work rejects the idea of a steady accumulation of knowledge, and rather aims to put on display historical discontinuities in systems of thought, and as a consequence, discontinuities in what is accepted as knowledge and thus taken to be credible and true. In this way, Foucault's project is to "show people that they are much freer than they feel" (Martin, 1988, p. 10) by illustrating that self-evident truths, that "go without saying", may actually be more "contingent, recent and modifiable than we think" (Gordon, 1991, p. 48). Foucault succinctly summarised this objective in an interview with Rux Martin in the late 1980s when he said:

> It is one of my targets to show people that a lot of things that are part of their landscape - that people are universal - are the result of some very precise historical changes. All my analyses are against the idea of universal necessities in human existence. They show the arbitrariness of institutions and show which space of freedom we can still enjoy and how many changes can still be made.
>
> (Martin, 1988, p. 11)

To achieve this objective, Foucault had to illustrate the shortcomings of traditional ideas, so influential in the human sciences, about human nature and a "foundational subject" that pre-exists social relations (Arribas-Ayllon & Walkerdine, 2008, p. 4). He would employ methods of historical inquiry to challenge these perspectives, and illustrate three ways in which human beings are *made into subjects*. Firstly, Foucault examines how the human sciences transform human beings into objects of study, e.g. the science of economics and the productive subject. Foucault also illustrates how scientifically derived norms operate through instruments and institutions and result in "dividing practices" that distinguish between subjects that are, for example, mad or sane, sick or healthy (Foucault, 1982, pp. 777-778). Finally, Foucault is concerned to illustrate how human beings turn themselves into subjects, and thus come to recognise and shape themselves in response to dominant systems of thought.

By illustrating the various and often contradictory ways in which systems of thought throughout history produce the subject of their inquiry, Foucault challenges foundational principles upon which many of the human sciences are built. In doing so, he also works to challenge the assumption that in our present time we have arrived at "a patch of sensibleness in a field of strangeness" (Kendall & Wickham, 1999, p. 23). Rather, Foucault would suggest that we come to view the way we are now with a greater scepticism, and consider that it is likely to be just as susceptible to ridicule with the arrival of a new system of thought. Thus, while Foucault does not set out a programme for how things ought to be, he challenges us to more closely examine and understand those events "that have led us to constitute ourselves and to recognize ourselves as subjects of what we are doing, thinking, saying" (Foucault, 1984c, p. 45).

1.2.Approaches to historical inquiry

Foucault devised methods of historical inquiry to achieve the objectives described above. He first put forward the method of 'archaeology' which, in contrast to traditional approaches to historical inquiry, involves selecting a particular *problem*

for investigation rather than a historical period (Kendall & Wickham, 1999, p. 22). He is thus concerned to excavate historical events and systems of thought which have served to shape the construction of particular problems at different points in time. Foucault applied this approach to the problem of madness in his first major work *Madness and Civilization: A History of Insanity in the Age of Reason* (Foucault, 1965). Within this text, Foucault traced the way in which madness was problematised throughout history, and the implications of different problematisations for the treatment of those categorised as 'mad'.

In this historical investigation, Foucault identified three distinct shifts in the treatment of madness. The first was from constructing the problem of madness as the presence of an evil spirit which needed to be driven out, to a revering of the mad during the Renaissance, where mad people were deemed to have special insights and a particular form of wisdom. However, during the Enlightenment, and the valorisation of reason, those deemed to be mad found themselves physically divided from society through their placement in asylums. In more recent years, while often no longer confined, those identified as irrational now find themselves transformed into patients that require treatment and cure through knowledge derived from the medical and psychological sciences. In bringing to light the ways in which systems of thought transform individuals into different types of subjects, Foucault's inquiry simultaneously served to illustrate the relation between knowledge and reality. While scientific knowledge in particular is most often considered as objectively describing an independent reality, here Foucault demonstrates that it may be more accurate to think of such knowledges as playing a substantial role in producing reality. The very real implications of new systems of thought for those identified as mad (i.e. social exclusion, medical intervention) illustrate this point.

During what has been described as his archaeological phase, Foucault would go on to produce two further texts which examined the historical shifts in the rules which govern knowledge and what is taken to be credible and true; firstly, *The Order of Things: An Archaeology of the Human Sciences*[1] (Foucault, 1970), followed by *The Archaeology of Knowledge* (Foucault, 1972). Foucault employed the concept of discourse within these archaeological texts, but is said to have "bracketed off" discourse from "the social practices and institutions in which it is embedded"

[1] References to the English language translations of Foucault's monographs are provided and thus do not reflect the timeline of publication of the original versions.

(Rabinow, 1984, p. 9), and thus focused solely on discourse as language. Later however, Foucault became dissatisfied with this approach, reflecting that at that time he "had not yet properly isolated" the "central problem of power" (Foucault, 1984b, p. 55). Thus, during his inaugural address at the Collège de France, Foucault introduced a revised method of historical inquiry which he called 'genealogy', an approach which would now include explicit analysis of the role of institutions, and power, in shaping knowledge and the "discursive regime" (Foucault, 1984b, p. 55).

> When I think back now, I ask myself what else it was that I was talking about, in *Madness and Civilisation* or *The Birth of the Clinic*, but power? Yet I'm perfectly aware that I scarcely ever used the word and never had such a field of analyses at my disposal.
>
> (Foucault, 1984b, p. 57)

It is this focus on the relation between power and knowledge which is most unique to the work of Foucault (Kendall & Wickham, 1999, p. 22), and it is discourse which is said to join power and knowledge together (Foucault, 1978, p. 100). Discourse, power, and the power-knowledge relation form the central components of a Foucauldian framework and in the following sections are each described in turn.

1.3.Discourse

As outlined above, Foucault's approach to conceptualising discourse shifted from an earlier focus on language alone, to a concern for the institutional rules, systems, and procedures which delimit discursive practice. It is this added attention to material conditions which distinguishes a Foucauldian notion of the concept from more mainstream uses. Examples which serve to usefully illustrate this relation between discourse and material conditions are found in *The History of Sexuality Volume 1* (Foucault, 1978). Within this text, Foucault challenges the general consensus that, over the past three centuries, sexuality has been repressed. While not disputing that there was indeed an increase in the "policing of statements" which resulted in "a whole restrictive economy" about what one could and could not say in relation to sexuality (Foucault, 1978, p. 18), it is Foucault's contention that simultaneously during these periods, there has been a "veritable discursive explosion" (Foucault, 1978, p. 17). To demonstrate this point, Foucault describes the changes which took place in the rules and requirements of confession. Confession was found to have become much more frequent over time, and additionally a new privilege was placed on the "sins of sexuality", with one author describing that these became "the cardinal sins", resulting in a change in "the 'league ladder' of sins" (Hunter, n.d. as cited in

Kendall & Wickham, 1999, p. 36). Thus, the confessional discourse, consisting of the rules, systems, and procedures of confession, resulted in an "institutional incitement to speak about" sex during this period (Foucault, 1978, p. 18). This example serves to illustrate that, for Foucault, discourse goes beyond words and language to include the culmination of events and practices which operate to produce reality.

> A task that consists of not - of no longer - treating discourses as groups of signs (signifying elements referring to contents or representations) but as practices that systematically form the objects of which they speak. Of course, discourses are composed of signs; but what they do is more than use these signs to designate things. It is this more that renders them irreducible to the language *(langue)* and to speech. It is this 'more' that we must reveal and describe.
>
> (Foucault, 1972, p. 49)

Importantly, Foucault is not interested in going behind discourse in an attempt to access a "non-discursive 'deeper' reality" (Kendall & Wickham, 1999, p. 39). For example, when investigating the historical construction of madness, Foucault is not trying to find out what madness *really is*; his sole concern is with the systems of thought and the associated rules, practices, procedures, and events which made it possible to speak of madness and recognise people as mad. Such a claim, as might be expected, has prompted the critique that Foucault denies the existence of an independent and material reality. However, this critique misinterprets what Foucault is proposing in his concept of discourse. To aid in clarifying the concept, the distinction is often made between the discursive, and the non-discursive realm. Kendall and Wickham (1999) employ a stark example to illustrate this distinction, bodily torture. The authors describe that while bodies themselves are indeed "non-discursive in their material reality", they do not "operate in a non-discursive vacuum" (Kendall & Wickham, 1999, p. 39). Additionally, while legal discourses and laws which permit the practice of torture under particular circumstances do not themselves directly attack bodies, it is within this discursive regime that such attacks can take place. Therefore, while not denying the material reality of the physical bodies involved in the act of violence, Foucault would encourage us to see that such practices are always within the realm of discourse, conceptualised as the rules, practices, procedures, and events which deploy systems of thought.

Both examples, of confession and torture, also serve to illustrate the close relation between discourse and power. Not unlike his concept of discourse, a Foucauldian notion of power is also said to be distinct from traditional perspectives. These

traditional perspectives more closely align with the example of torture, where power is visible, violent, and oppressive. In contrast, the example of confession, provided by Foucault himself, demonstrates a subtle, wide-reaching form of power which operates to govern behaviour. It is to this Foucauldian notion of power that we now turn.

1.4.Power

An integral part of Foucault's work in demonstrating how people are constituted through discourse, and indeed constitute themselves within discourses, is providing an alternative approach to conceptualising power and how it functions. As described above, traditional perspectives most often view power in terms of visible manifestations (e.g. violence), or as something bestowed upon individuals through state institutions and the law e.g. judges, army, and the police. Illustrating the latter perspective, Foucault famously remarked that, particularly when it comes to political analyses of power, "we still have not cut off the head of the king" (Foucault, 1978, p. 89). As such, Foucault suggests that thinking about power as a commodity of a centralised agency captures only part of the picture, and importantly fails to account for the ways in which less overtly violent forms of power are exercised in a more constant way to govern societal conduct. As described by Arnold I. Davidson in his Introduction to Foucault's lecture series *Society Must Be Defended,* Foucault's writings are thus responses to the "conceptual impasse" that comes with analysis of power only in terms of the state and the law, and as such are "attempts to articulate alternative ways of analyzing power" (Foucault, 2003, p. xvii). The below quote perhaps best illustrates Foucault's scepticism and critique of the traditional approach to conceptualising power.

> It is defined in a strangely restrictive way, in that, to begin with, this power is poor in resources, sparing of its methods, monotonous in the tactics it utilizes, incapable of invention, and seemingly doomed always to repeat itself. Further, it is a power that only has the force of the negative on its side, a power to say no; in no condition to produce, capable only of posting limits, it is basically anti-energy.
>
> (Foucault, 1978, p. 85)

Moving beyond this negative and repressive notion of power, Foucault suggests that we start to see power as a positive and productive force. For Foucault, the productive capacity of power is most evident in the mode through which it produces subjects. It is not a direct or forceful power but rather achieves its effects through the establishment of societal perceptions as to what is normal, ethical, or moral

behaviour. In more recent times the guiding principles for society have been derived from the ideas underpinning the Enlightenment, and as such are oriented towards reason and personal autonomy. Such principles become subsumed into discourses and institutions, and in this way society sets out the values by which we should live, and indeed the kinds of people that we should strive to be e.g. honest, a good student. The positive and productive force of power is thus enacted through the ways in which individuals "police themselves by examining, confessing, and regulating their own thoughts and behaviour in accord with a certain concept of normality" (Bevir, 1999, p. 66).

The second way in which Foucault has reconceptualised power is through challenging the perspective that power can be understood as a commodity that some people or institutions can possess and thus exert upon others. His concern is simply that "when one treads endlessly in the double question: What is power? and Where does it come from?" (Foucault, 1982, p. 786), the complex reality of power is lost. Thus, he encourages us to approach the analysis of power guided by the question of '"How," not in the sense of "How does it manifest itself?" but "By what means is it exercised?"' (Foucault, 1982, p. 786). In answering this question, Foucault suggests that power is better thought of as passing through people, rather than being exercised by people.

> Power is exercised through networks and individuals do not simply circulate in those networks, they are in a position to both submit to and exercise this power. They are never the inert or consenting targets of power; they are always its relays. In other words, power passes through individuals. It is not applied to them.
>
> (Foucault, 2003, p. 29)

Thus, for Foucault, power is "a strategy that is immanent in force relationships" (Foucault, 1978, p. 97), and one which can be understood as a "mode of action which does not act directly and immediately on others" but instead "it acts upon their actions" (Foucault, 1982, p. 789). It is important to highlight here that Foucault avoids making normative assessments about the nature of power. That is, for Foucault power is neither 'good' nor 'bad', neither 'right' nor 'wrong'. Instead, the concern is to understand the operation of power, and how it comes to be more or less effective in shaping our realities. Kendall and Wickham (1999, p. 48) thus advise that we move away from notions of power as "always something hidden in the background doing dirty work", and instead come to think of power simply as energy, circulating through networks and acting upon people's actions.

Foucault provides a useful example to illustrate this concept of power. He draws on the model of the Panopticon, an architectural design proposed by the philosopher Jeremy Bentham towards the end of the 18th century. The design of the Panopticon is a central circular tower surrounded by a ring shaped building composed of individual cells. As Foucault describes all "that is needed, then, is to place a supervisor in a central tower and to shut up in each cell a madman, a patient, a condemned man, a worker or a schoolboy" (Foucault, 1977, p. 200). The supervisor from the central tower will be able to see into all the individual cells, while the inmates will be unable to see if the central tower is occupied. In this way, the model serves "to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power" (Foucault, 1977, p. 201), regardless of whether or not the tower is indeed occupied. For Foucault, the Panopticon epitomises the local, constant, and indirect nature of power acting on the actions of others to bring about their own self-regulation and conduct reflective of societal norms. Much of Foucault's work then is dedicated to bringing to light different "technologies of power" (Foucault, 1977, p. 131) which indirectly, and through a multitude of force relations, transform human beings into subjects, and govern their conduct in society.

The final element of a Foucauldian notion of power concerns the relation between such forms of power and knowledge. Again, critiquing the dominant perspective, Foucault challenges the idea that pure knowledge emerges only when "power relations are suspended", and logic and reason are free to thrive (Foucault, 1977, p. 27), and rather suggests that there exists a constant and reciprocal relation between power and knowledge.

1.5.Power-knowledge

A central focus of the Foucauldian project has been to demonstrate the intimate relation between power and knowledge. As outlined above, the nature of power in which Foucault is interested is a subtle, nuanced form of power, operating through a multiplicity of force relations and acting upon the actions of others, or indeed shaping how we come to act upon ourselves. The knowledge of interest to Foucault in his major works was predominantly expert knowledge produced through scientific discourses, and included disciplines such as psychiatry, psychology, criminology, biology, sexology and medicine.

It was Foucault's contention that there is no knowledge without power, and he thus remarked:

> The exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power.

(Foucault, 1980b, pp. 51-52)

To illustrate the operation of this reciprocal and reinforcing power-knowledge relation, I will use here Foucault's concepts of biopower and governmentality, and the example of the psychological complex proposed by Nikolas Rose. Biopower is perhaps one of Foucault's most well-known ideas and relates to what he saw as an extraordinary shift in power-knowledge relations in the 18th and 19th centuries which, as a result of new scientific forms of knowledge, saw the biological (the body) come under control of the state (Foucault, 2003, p. 240).

> What does this new technology of power, this biopolitics, this biopower that is beginning to establish itself, involve? I told you very briefly a moment ago; a set of processes such as the ratio of births to deaths, the rate of reproduction, the fertility of a population, and so on. It is these processes—the birth rate, the mortality rate, longevity, and so on—together with a whole series of related economic and political problems … which, in the second half of the eighteenth century, become biopolitics' first objects of knowledge and the targets it seeks to control.

(Foucault, 2003, p. 243)

Up to this point, the target of knowledge had tended to be individuals and families. However, with the emergence of new forms of scientific knowledge from disciplines such as epidemiology, demography, and statistics, came a new desire to control the body politic or whole populations. In discussing the change in historical perspectives on life and death, Foucault suggests that with the development of new statistical techniques, such as the ability to determine life expectancy, death was no longer treated as sudden and permanent but rather something "that slips into life, perpetually gnaws at it, diminishes it and weakens it" (Foucault, 2003, p. 244). Thus, for the first time, the longevity, and indeed the efficiency and productivity, of the "national stock" came under the control of the state (Rose, N., 2001, p. 2). Foucault termed this new art of governing the population "governmentality" (Foucault, 2007, p. 435). As we shall see in Chapter 2, this newfound ability to measure populations, and in particular identify differences between subgroups of the population, would pave the way for greater attention to be directed towards addressing what we now call health inequalities.

The close relation between the political objective to control and improve the quality and longevity of the population, and scientific knowledge, is perhaps best exemplified by Rose's psychological-complex (Rose, 1979). Briefly, the objective of Rose's work was to illustrate the historical processes through which psychology transformed from simply a discipline, to a complex of "agents, of practices, of discourses and apparatuses" (Rose, 1979, p. 6). Additionally, Rose sought to illustrate how, through the instruments of mental measurement and differentiation, psychological knowledge became enmeshed in the political objective of improving the characteristics of the population. Psychological tools were said to produce objective knowledge of the inner capacities and capabilities of human beings, and thus single out defective individuals and groups for surveillance, guardianship of the state, and indeed in some cases forced sterilisation (Rose, 1979, p. 14). Situated against the backdrop of a eugenics discourse in the United States at the time, Rose highlights how discourses of intelligence, degeneracy, and heredity intersected to result in "the simultaneous constitution of a problem, of its explanation, of its solution, and of the means by which this solution is to be effected" (Rose, 1979, p. 12). Using this example, Rose clearly illustrates the reciprocal relation of power and knowledge, and the role of discourse in shaping realities through, as Foucault would say, constructing the objects of which they speak.

For many, this characterisation of the power-knowledge relation has been likened to ideology. However, Foucault himself rejected the concept of ideology on a number of grounds, most notably on ontological grounds. The concept of ideology presupposes the existence of an independent and knowable truth or reality, and indeed the existence of subjects that have the capacity to know this reality. However, as highlighted earlier in the chapter, Foucault is not interested in getting to the truth of a matter, but rather is interested in *how* some things came to be accepted as true at different points in history. Thus for Foucault, rather than ideology, it is the politics of truth or 'regimes of truth' which are of interest.

> Each society has its regime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true.
>
> (Foucault, 1984b, p. 131)

Such ‘how’ questions bracket normative judgements about whether knowledges or practices are right or wrong, or good or bad, but rather the focus of inquiry is on bringing to light the mechanisms of power that sustain these ‘regimes of truth’. Similarly, for Foucault there is a danger that by focusing solely on the pivotal role of the state or the elite in sustaining a warped knowledge of reality, as is often the case when employing the concept of ideology, we may fail to appreciate the dispersed nature of power that operates beyond the confines of the state.

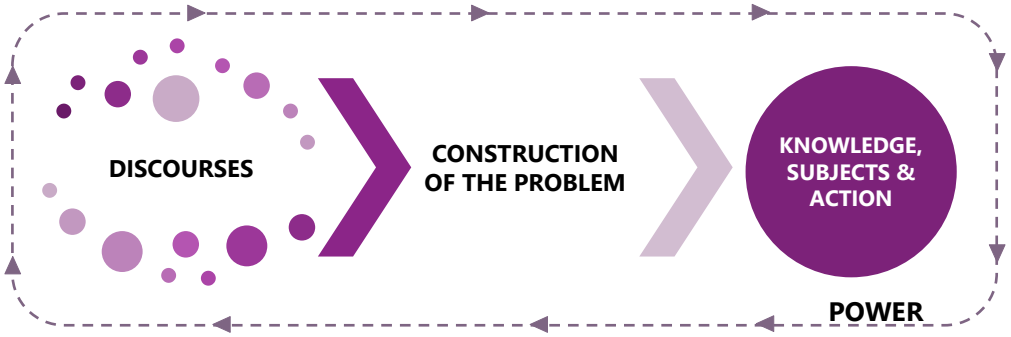
> I don’t claim at all that the State apparatus is unimportant, but it seems to me that among all the conditions for avoiding a repetition of the Soviet experience and preventing the revolutionary process from running into the ground, one of the first things that has to be understood is that power isn’t localised in the State apparatus and that nothing in society will be changed if the mechanisms of power that function outside, below and alongside the State apparatuses, on a much more minute and everyday level, are not also changed.
>
> (Foucault, 1980a, p. 60)

Foucault’s concepts of discourse, power, and the power-knowledge relation are thus intended as tools to examine ‘regimes of truth’ and understand how power operates at the level of the everyday to sustain some ways of looking at and understanding problems over others.

1.6.A Foucauldian framework

The relationship between the concepts presented above, discourse, power, and power-knowledge, are illustrated in the framework presented in Figure 1. As Arribas-Ayllon and Walkerdine (2008, p. 2) outline, “it is customary to offer the disclaimer that there are no set rules or procedures for conducting Foucauldian-inspired analyses of discourse”, and so this framework is intended to illustrate the perspective employed in the work, and the resulting predisposition to look out for these related phenomena throughout the thesis.

Figure 1. Components of a Foucauldian framework



As shown in Figure 1, in a Foucauldian framework the concern is firstly with how problems are constructed, and the multiple competing discourses which operate to shape and frame problems in particular ways. Reflective of Foucault's conceptualisation of power, it is shown here in Figure 1 as circulatory, and operating through discourse, to produce knowledge and subjects, and as a consequence operating to shape action. This framework is employed in Chapter 2 where I present a historical inquiry into the evolution of the problem of health inequalities in an effort to trace the dominant discourses to which the upstream parable emerged as a response. Additionally, this framework provides the underpinning theory for the methodological approach employed in the thesis, and described later in Chapter 4.

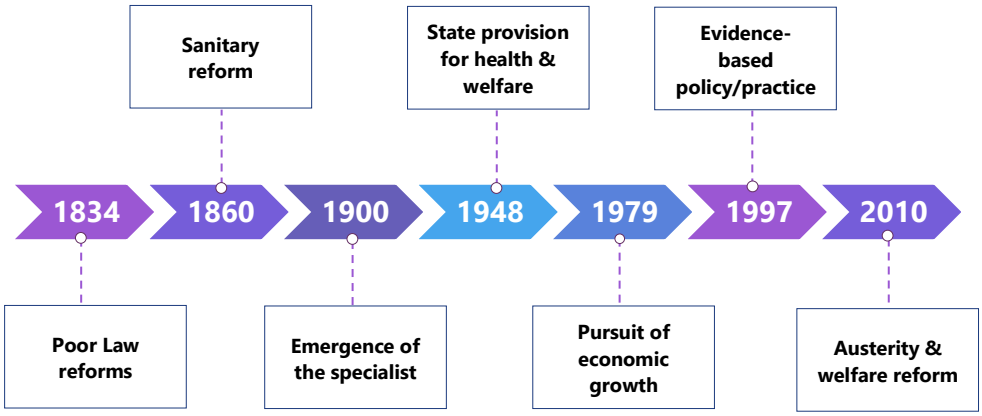
1.7.Chapter summary

The purpose of this chapter has been to introduce the work and ideas of Michel Foucault and present the theoretical perspective employed in the thesis. As outlined, a central component of any Foucauldian inspired inquiry is tracing the historical evolution of the problem of interest and its various problematisations. And so, in Chapter 2 and using the Foucauldian framework outlined above, I present a historical inquiry into the problem of health inequalities which goes beyond recounting theoretical developments, to a focus on 'regimes of truth' and the operation of discourses in sustaining particular ways of looking at, and understanding the problem. Through this account it becomes possible to identify precise historical events which culminated in the emergence of the upstream parable.

CHAPTER 2: HEALTH INEQUALITIES - A HISTORY OF THE PRESENT

A central component of a Foucauldian inspired inquiry is tracing the historical evolution of the problem of interest. In this chapter, I employ the Foucauldian framework presented in Chapter 1 to trace how the problem of health inequalities has been constructed at different points in time, and in doing so I illustrate how the problem has transformed over time. In providing this "genealogical background" to the study (Arribas-Ayllon & Walkerdine, 2008, p. 2), I illustrate the conditions which gave rise to the emergence of the upstream parable in recent years, and provide the rationale for treating the upstream parable as a counter-discourse in the field of health inequalities. The chapter is structured into seven sections that deal chronologically with political and scientific discourses which have each operated to powerfully influence constructions of the problem of health inequalities, and as a consequence have shaped policy and practice. These developments are shown in Figure 2.

Figure 2. Historical developments shaping the problem of health inequalities



Through examination of such developments, and in particular government policy and responses to the problem, it is possible to bring to light the ways in which problems are "created" and "given shape" (Bacchi, 2000, p. 48). Indeed, Kendall and Wickham (2004, p. 8) suggest that a Foucauldian approach is akin to writing a detective story, where the outcome is known but what is needed is an account of the precursors leading up to this outcome, so that we may fully understand the

emergence of the problem and related discourses. While some of Foucault's historical investigations trace back to Ancient Greece, I have chosen the somewhat more modest starting point of the early 19th century.

2.1.The 'feckless poor' and the New Poor Law

Although notable reports prior to the 19th century began to lay the foundations for investigating health differences between social class groups (e.g. for example William Petty's (1623-1687) *Political Anatomy of Ireland* and John Graunt's (1620-1674) *Observations upon the Bills of Mortality*), the discourse of the 'feckless poor' is said to have dominated public debate at this time. In particular, during the industrial revolution, alcohol consumption, crime, and illegitimacy were considered characteristic of the working-class groups (Hanlon, Carlisle, Hannah, Reilly, & Lyon, 2011). As a consequence, ill health amongst the poor was often attributed to their 'feckless' nature, a conclusion which is said to have complemented the liberal values of the commercial classes at the time who, as Szreter writes, were committed to ideals of individualism, non-intervention in the industrial economy, and low levels of taxation (Szreter, 1997). As such, constructing the social patterning of health and illness in terms of individual failings on the part of the working-classes obviated the need for any state support or assistance.

An additional manifestation of the discourse of the 'feckless poor' was the *Poor Law Amendment Act* of 1834, which served to overhaul the social security system in the interests of the economy (Szreter, 1997). Three theories underpinned the reform: (1) that the *Old Poor Law* was encouraging illegitimacy, (2) that the system was undermining the wages of independent workers, and (3) that claiming relief had to be unpleasant if it were to be reduced (Spicker, 2017). Szreter describes how the discourse at the time operated to distinguish between the "idle poor" and the "productive rich", with the resulting *New Poor Law* "all but criminalising the poor, who were treated as work-shy moral delinquents" (Szreter, Kinmonth, Kriznik, & Kelly, 2016, p. 2735). However, towards the mid-19th century, the production of new knowledge, in the form of observational statistics, served to challenge this dominant discourse and bring to light the role of living and working conditions in shaping the health outcomes of the lower social class groups.

2.2.Living conditions and local government action

Influential works at this time included *The Condition of the Working Class in England* (Engels, 1845) and the *Report on the Sanitary Condition of the Labouring Population of Great Britain* (Chadwick, 1842). Each contributed knowledge of the relationship between living conditions and health, and in doing so highlighted disproportionate levels of mortality amongst lower social class groups. In Foucauldian terms, the productive power of this new knowledge was evidenced by the introduction of new laws and the establishment of dedicated institutions. For example, a new *Public Health Act* was passed in 1848, and just prior to this in 1837, the new General Register Office (GRO) was created which collated census and vital registration statistics. However, this new discourse, constructing the problem of the social patterning of health and illness in terms of living conditions, would not gain immediate traction amongst those with the power to implement reforms. It is therefore worth briefly detailing the events which led to the eventual sanitary reforms of this seminal period.

As the relationship between social conditions and health was generally undisputed by the mid-18th century (Szreter, 1997), the delay in implementing the necessary reforms was attributed to the expense being counter to the financial interests of factory and workshop owners, landlords, and shopkeepers at the time (Hamlin, 1988; Szreter, 1988). There was also a clear opportunity cost for those who would foot the bill, where investment in infrastructure that held more immediate commercial advantage was prioritised, for example the development of railway connections (Szreter, 1997). However, despite this reported reluctance, large-scale reforms in infrastructure did take place. Three things in particular have been put forward to explain the change of pace in local action from the 1860s onwards. Firstly, was the role of the "civic gospel", which Szreter describes as "a social movement in the town halls of Britain's new industrial cities" (Szreter, 1997, p. 709). This social movement reflected a new, religiously derived civic consciousness that espoused acts of public good. The "civic gospel" was also thought to form part of a wider belief in the possibility of social progress and improving the character of the working-classes (Szreter, 1997, p. 710), a distinct shift in thinking from the earlier discourse of the 'feckless poor'.

Secondly, the tactics of the GRO have been noted as influential in generating the political will necessary to implement the reforms. These tactics included a "major propaganda campaign" waged on local ratepayers and their elected officials (Szreter,

1991, p. 436). By regularly reporting scandalous mortality data, the GRO was successful in stirring up public interest in their statistics, fostering an atmosphere of competition and rivalry between local authorities, and generating urgent debate on matters of public health action (Szreter, 1991). For example, a notable statistic included in William Farr's 1843 comparative life-tables showed that almost half of the people born in Liverpool were dying before their 6th birthday, a rate only seen in the national population for people who had passed their 45th birthday (Szreter, 1991, p. 436). Finally, eventual action on sanitary reforms is said to have been influenced by the change in voter demographics as a consequence of electoral reform in the late 1860s. Increased voting privileges meant that for the first time the interests of the non-ratepaying manual working classes featured strongly in the calculations of local politicians (Szreter, 1997, p. 710).

These changes, in response to the sanitary reform discourse, served to reposition the poor and manual working-class groups from being personally responsible for their own poor health, to being victims of the squalor of industrialisation and rapid urbanisation. The sanitary reform discourse produced not only new knowledge and ideas, but also new laws, institutions, and public service infrastructure that would leave a permanent stamp on public health history. Indeed, as we will later see, it is this "heroic age" of public health activism and social reform (Szreter, 1988, p. 21) which is most often invoked in calls to re-engage both with the roots of public health, and the root causes of health inequalities. The public health discourse would however, in the late 1880s, be swept up in a new scientific discourse in the form of germ theory. This development would have important implications for the social reformists of this era, and for future approaches to problematising the causes of disease and the social pattern in health and illness.

2.3.Single causes of disease and the rise of the specialist

For Foucault, new overarching systems of thought, or 'epistemes', do not come around too regularly, and so the shift in thinking from the sanitary reform era to germ theory is perhaps more accurately considered as a Kuhnian paradigm shift (Susser & Susser, 1996). The paradigm of the sanitary reform era was miasma (i.e. foul emanations as the major cause of disease), whereas germ theory now centred on the role of microorganisms. Pioneers at this time included John Snow (1813-1858) and his study on the mode of transmission of cholera (Snow, 1855); Louis Pasteur (1822-1895) who in 1865 identified a living organism as the cause of an epidemic affecting

silkworms (Susser & Susser, 1996); and Robert Koch (1843-1910) who established a mycobacterium as the cause of tuberculosis (Koch, 1982). This new knowledge, that diseases could be understood in terms of single specific infectious agents, transformed the public health discourse profoundly. In stark contrast to the proceeding era, germ theory's triad of host, agent, and environment shifted the emphasis from social conditions to specific microbial agents with little consideration of the impact of human agency on host and environment (Krieger, 2000, p. 158).

This new paradigm discredited miasma, and resulted in those who favoured the traditional public health philosophy being positively "disparaged" during this transition (Susser & Susser, 1996, p. 670). Krieger notes a dramatic shift in the orientation of public health practitioners, from a strong social activism role in the 1800s, to academia and social advocacy becoming like "oil and water", where more social accounts of disease causation were deemed to be "polluted by politics" (Krieger, 2000, p. 158). Earlier in this period it was commonplace to speak of the causes of disease as being situated within the environment. However, it is evident that it became increasingly difficult, in light of this new scientific discourse, to suggest that the *real* causes of disease could indeed still be traced to a social pattern in the quality of living conditions.

With this new scientific discourse came new concepts. The concept of the expert in particular is said to have emerged during this period (Hanlon et al., 2011, p. 31), with Szreter (1988) suggesting that this new specialist status operated to position middle-class professional agents as "social superiors", with knowledge to impart to improve the behaviours of the unlearned working-classes. While this move to more paternalistic approaches to population health was at loggerheads with the libertarian philosophy and respect for domestic privacy of this time, important historical events in the years that followed would serve to dramatically reshape public perceptions on the role of science, medicine, and the state in supporting population health and addressing the uneven distribution of health in society.

2.4.Collective optimism and state intervention

As briefly discussed in Chapter 1, Foucault himself explored the implications of new forms of knowledge, which went beyond consideration of the health of individuals, to focus on the health of populations. The result of this new knowledge was that the longevity, efficiency, and productivity of the "national stock" became a concern of the state (Rose, N., 2001, p. 2). One stark example, which relates to the fitness of

war recruits, serves to usefully illustrate how the health of the poor became a problem for the state. During the Boer War, departmental reports note that at times up to 40% of recruits were documented as unfit to enlist, with anecdotal observations suggesting a much higher rate of 60% (Inter-Departmental Committee on Physical Deterioration, 1904, p. 96). Additionally, a number of seminal reports published at this time further offered up to government the physical health and fitness of the poor as a problem to be addressed (Booth, 1903; Rowntree, 1901). In response to these concerns, the Liberal Party, elected to government in 1906, instigated a raft of social reforms (e.g. old age pensions, free school meals, national insurance). These reforms were intended to improve population health and thus improve national efficiency.

However, initially there was much scepticism about the motives of the Liberal government, and public support for the reforms was not immediate. Initial concerns were attributed to the fact that the proposed reforms came from politicians who have been described as "distinctly not socialist" (Thane, 1984, p. 881). As such there was a sense that the reforms were merely a way to preserve, and perhaps even strengthen, the existing social and economic order. Even more concerned about the impacts of the reforms were revolutionary labour movement organisations who assumed that the poorer working-classes felt that there was more to be gained from reforms to the existing state, than the uncertainty of a transition to socialism (Thane, 1984, p. 881). Additionally, such groups feared that the reforms would strengthen capitalism, through increased complacency of workers and diminished class struggle (Thane, 1984, p. 883).

In the decades that followed however, as the country endured two World Wars, popular perspectives on the role of the state and state intervention would undergo a major transformation. The post-war period saw a time of greater equality of income, and a new sense of collectivism and equality for all (Dorling, 2013). This was helped by increased mixing of social class groups due to evacuation to rural areas from the heavy bombing of industrialised cities, and the extension of free care in hospital beyond only those who were categorised as contributing to the war effort (Abel-Smith, 1992). Abel-Smith remarks that indeed the idea of a comprehensive hospital service had its own momentum at this time, with the *Beveridge Report* providing "no more than a push forward" (Abel-Smith, 1992, p. 13). The *Beveridge Report*, published in 1942, set the scene for post-war reconstruction and the establishment of the welfare state. The report's recommendations were intended to address the five giant evils of want, disease, ignorance, squalor, and idleness. The positive worldwide

reception and interest in the *Beveridge Report* is attributed to what Burns describes as the "temper of the times"' and the aspirations for a "better post-war world" (Burns, 1943, p. 512).

The Labour Government elected in 1945 was responsible for implementing the recommendations of the report, and on the 5th of July 1948 universal health provision was brought into existence through the National Health Service. It would subsume existing infrastructure including voluntary hospitals, which, despite their ability to work effectively outside of the confines of bureaucratic state action, demonstrated significant regional variation and geographic inequalities in service provision (Gorsky, Mohan, & Powell, 1999). However, despite early optimism that a universal health service would resolve this problem of regional disparities in service provision, and as a consequence address the social patterning of health and illness, the publication of the "inverse care law" in 1971 actually showed that the availability of good medical care tended to vary inversely with need (Hart, 1971). Around the same time, the idea of achieving 'equity' was emerging as an increasingly legitimate goal of national health systems, exemplified in the development of the Resource Allocation for Equity Working Party in the mid-1970s (Gorsky & Millward, 2017). The establishment of a universal health service would have important implications for problematising health, where in the decades that followed, health often came to be equated simply with healthcare, and consequently health equity became equated with equal access to services (Bambra, Fox, & Scott-Samuel, 2005).

Nevertheless, these events did serve to catapult what were now called 'socioeconomic inequalities in health' back into consciousness, and in response, an independent inquiry was established in 1977. However, the enthusiasm was short-lived and the fate of the resulting *Black Report* (DHSS, 1980), which did indeed confirm that socioeconomic inequalities in health were widening, is now infamous. The period which follows demonstrates the most significant shift in the problematising of these socioeconomic inequalities in health, and indeed inequality more widely.

2.5.Neoliberalism and the New Right

In stark contrast to the previous eras, from the late 1970s the question was no longer oriented towards understanding and addressing socioeconomic inequalities in health, but rather introducing the perspective that inequality itself was not a problem, and certainly not a problem to be addressed by government. It is illuminating therefore

to examine how the neoliberal discourse espoused by Margaret Thatcher and the New Right at the time served to legitimate and justify not only inaction on inequalities in income, wealth, and health, but indeed action that would knowingly result in widening inequalities.

Szreter suggests that by the late 1970s, the achievements of the previous three decades had become so taken for granted, that populations were lured by the promise of "Fools' Gold" in the form of lower personal taxes and a reduction in public services (Szreter, 1997, p. 716). Equally, the breakdown of industrial relations during the 'Winter of Discontent' provided the opportunity to exploit an "anti-union narrative" and convince the public that social democracy and working-class power were the causes of Britain's new found "Sick man of Europe" status (Scott-Samuel et al., 2014, p. 56). Furthermore, it has been suggested that the work of influential epidemiologist Thomas McKeown also served to bolster the New Right in their radical questioning of the welfare system and state intervention. The McKeown thesis sought to challenge the excessively technocratic and curative model of medical practice, and highlight the role of economic growth, rising living standards, and improved nutrition on mortality decline (Szreter, 2002, p. 722). However, as Szreter highlights, in a rapidly changing political climate, the McKeown thesis (which was later shown to be somewhat flawed (Szreter, 1988)) was employed by the New Right to suggest that strong economic growth was the *only* way to guarantee continued improvements in living standards and health for all (Szreter, 2002, p. 723).

Hickson (2009) provides a detailed analysis of the attitudes of the various factions of the Conservative Party to poverty and inequality during this period. He notes that the New Right were committed to increasing inequality in income and wealth, and regarded poverty as an "absolute condition" (Hickson, 2009, p. 342). As such, there was a commitment to reduce residual cases of *absolute* poverty, but no desire to go beyond this and tackle *relative* poverty, which was a problem that simply did not exist in the minds of the New Right (Hickson, 2009, p. 345). The most effective means for reducing absolute poverty was through the free market which would stimulate economic growth, wealth creation, and an eventual trickle down to the poor (Hickson, 2009, p. 352). Thus rising inequalities in income and wealth were deemed to be a necessary condition for improving living standards for all. Additionally, it was considered impossible to realise the conservative value of individual freedom, while also pursuing an egalitarian agenda, as equality and freedom were seen as "diametrically opposed" (Hickson, 2009, p. 347). The moderate faction of the party

at this time, the One Nation Conservatives, while still opposing equality as an explicit objective for government, did subscribe to the concept of relative poverty. It was felt that definitions of poverty were deemed only to make sense when the position of the poor was considered in relation to the rest of society (Hickson, 2009, p. 354). Additionally, considerations of relative poverty were seen as essential for maintaining social relations, with the One Nation Conservatives expressing a concern for the relationship between social policies and civic unrest, and a responsibility on the part of government to offset the negative by-products of the free market and unregulated economic growth (Hickson, 2009, p. 355).

Despite some contrasting perspectives within the ruling party at this time, the overall rejection of a political goal to reduce inequalities in income and wealth, and as a consequence health, is clear. This period signifies a distinct shift from the collectivism espoused in the early part of the century to a new emphasis now placed on individual merit, hard work, and the unavoidable social stratification of society. As such, widening inequalities were no longer considered problematic, but rather as reflecting the way things are, and indeed the way they ought to be. The legacy of these final decades of the 20th century was that inequality was an unavoidable, and arguably desirable feature of society that stimulated innovation, entrepreneurialism, hard work, and wealth creation, and that all of society would be brought along with the wealth creators to a greater or lesser extent. After 18 years of rule however, public support for the New Right did eventually wane. New Labour were waiting in the wings with a vision that it proposed went beyond the Old Left and New Right to carve out a Third Way. The Third Way, as a political philosophy, has been subjected to extensive analysis and critique over the last twenty years, and rather than representing a "new and distinctive approach" (Powell, 2000), it has been suggested that that the Third Way is more accurately described as an extension of, and adaptation to, Thatcher's new political agenda. Indeed, the legacy of Thatcherism and the New Right has been described as serving to engineer a new "political middle ground" (Heffernan, 1998).

2.6.New Labour and the Third Way

It was this new political middle ground which was said to have created the conditions for New Labour to introduce onto the political agenda what were now most often described as 'health inequalities'. Wainwright (1996) describes that while British socialism was in steady decline during the 1970s and 1980s, it was still perceived to

be a legitimate threat to government. As a consequence, the findings of the *Black Report* (DHSS, 1980) and *The Health Divide* (Whitehead, 1987), which both produced damning evidence of the role of the social and economic order in shaping class-based differences in health, were heavily challenged. Speaking about the pursuit of capitalism, Thatcher famously suggested that there was no alternative, and Wainwright (1996) outlines that it was not until this suggestion had come to be taken as a universally accepted fact, that the objective of addressing health inequalities, within the limits of capitalism, could now be introduced onto the political agenda. Thus, while New Labour were the first political party in the UK to explicitly set out to reduce health inequalities, even setting national targets for their reduction (Department of Health, 2002, p. 12), this period for many is viewed as a contradiction in terms, which fuelled the idea that it could be possible to reduce health inequalities while simultaneously widening income inequality through the pursuit of neoliberal policies (Bambra et al., 2005).

Of particular concern to commentators at this time was New Labour's espoused philosophy of pragmatism and rationalism, which is said to have resulted in a party oriented towards "solving discrete problems" (Lister, 2001b, p. 433). This philosophy, coupled with the party's championing of evidence-based policy and practice discourses (Wells, 2007), powerfully operated to shape the problem of health inequalities and policy action. The rationale for employing an evidence-based discourse was the move away from the dogma of "outdated ideology", to a focus on "what works" (Labour Party, 1997). However, this stance is said to have ultimately culminated in a move away from New Labour's initial commitment to addressing structural determinants of health, to a focus on targeting individual behaviour change (Smith et al., 2009). This reorientation is reflective of the 'lifestyle drift' discussed in the Introduction to the thesis, a phenomenon which has recently been investigated in its own right. Williams and Fullagar (2018), for example, set out to explicitly examine the mechanisms through which lifestyle drift manifested in New Labour spearhead areas. The authors conducted an ethnographic study of a low-income neighbourhood in England which had been the focus of two area-based initiatives including a New Deal for Communities regeneration grant and a Sport Action Zone. While efforts were initially oriented towards changing health behaviour through action on the social determinants, responsibility for change over time was found to be progressively pushed back onto residents, in a process that the authors describe as "citizen shift" (Williams & Fullagar, 2018, p. 6).

Despite these critiques however, recent evidence has suggested that the policies of the New Labour health inequalities strategy had been effective in reducing geographic inequalities in health (Barr, Higgerson, & Whitehead, 2017). Indeed, some authors have suggested that the New Labour project was an exercise in "doing good by stealth" (Lister, 2001a). Nevertheless, the legacy of New Labour has been to further demonstrate the challenge of reorienting efforts away from the 'hard' version of the cultural/behavioural explanation for health inequalities (see Introduction). Indeed, Tony Blair once remarked that efforts to outlaw social inequalities could be explained by a failure to address lifestyle behaviours:

> Our public health problems are not, strictly speaking, public health questions at all. They are questions of individual lifestyle - obesity, smoking, alcohol abuse, diabetes, sexually transmitted disease.

("Blair calls for lifestyle change," 2006)

As a result of this framing of the problem of health inequalities, and the resulting emphasis on individual behaviour change, the thinking of New Labour is now considered by some to be "part of the problem rather than part of the solution to reducing inequalities in health in Britain" (Dorling, Shaw, & Davey Smith, 2007, p. 16). Despite this rather damning assessment, arguably nothing could be quite as problematic for the agenda of reducing inequalities in health in Britain, as was the 2008 global financial crisis, which would ultimately bring to an end New Labour's time in government.

2.7.Austerity and the shrinking state

The Conservative-led coalition government would find themselves at the forefront of the austerity discourse in 2010, and tasked to implement a raft of spending cuts including large-scale cuts to both central and local government, NHS funding freezes, welfare reform and service privatisation. While the then Shadow Chancellor George Osborn famously remarked at the time that "we are all in this together" ("Osborne gambles with cuts plans," 2009), analyses have shown that the largest budget cuts were planned in the most deprived areas (Taylor-Robinson & Gosling, 2011). Additionally, the cuts were systematically larger in the North of England and in the areas with the highest premature mortality (Taylor-Robinson, Gosling, Harrison, Khan, & Barr, 2013). On top of funding losses in public services, over £5bn is said to have been lost to welfare reforms in the North of England alone (Inquiry Panel on Health Equity for the North of England, 2014).

The implications of the global financial crises, and the resultant austerity agenda, have been profound. The number of people reporting mental health problems increased significantly after 2008, with the greatest increase amongst those people with low levels of education (Barr, Kinderman, & Whitehead, 2015). Changes in suicide trends have also been identified, with almost half of the post-recession increase in suicides attributable to rising unemployment (Barr, Taylor-Robinson, Scott-Samuel, McKee, & Stuckler, 2012). Additionally, dramatic changes have been recorded in the prevalence and use of food banks nationally for individuals experiencing food insecurity. Despite suggestions that people may simply be taking advantage of food made freely available (Williams, 2013), Loopstra et al. (2015) demonstrated that the pattern in the rise of foodbanks is more likely the result of extensive cuts in local services, benefit cuts and sanctions, and higher unemployment rates in these areas.

Not unlike the suggestion that there is no alternative to capitalism, the idea that there is no alternative to austerity has been shown to have quickly taken on the status of indisputable truth (Reeves, Basu, McKee, Marmot, & Stuckler, 2013). The austerity discourse has been powerful in its effects, with authors suggesting that the discourse, and the associated "politics of debt" (Reeves et al., 2013, p. 435), have operated to bring about a reinvigorated attack on universalism and the welfare state. This is in contrast to the collectivism that prevailed in the post-war era (Section 2.4), where people were prepared to contribute to a safety net, and accept rationing of essentials to ensure availability and security for all (McKee & Stuckler, 2011). The impact of austerity in the UK has been likened to the weakened support for social welfare in the United States where, in an increasingly divided society, the welfare state is no longer seen as a means of protecting one's family against catastrophe but rather "as a payment to people with whom one has little shared identity" (McKee & Stuckler, 2011). While the problematising of health inequalities has been less at the forefront of political debate, particularly in the recent years following the UK European Union membership referendum in 2016, it is important to conclude this chapter by stressing that current efforts to address health inequalities continue to be set against a backdrop of a powerful austerity discourse.

2.8.Chapter summary

The aim of this chapter has been to provide a Foucauldian inspired historical account of the problem of health inequalities, and illustrate the influential discourses and

'regimes of truth' which have operated to produce different constructions of the problem at different points in time. While health inequalities were, for some time, understood as the consequence of hazardous living and working conditions, along with the inequitable distribution of material resources, since the late 1970s the problem has undergone a profound transformation. In the 1980s and 1990s the problem was simply dismissed as non-existent, and despite initial suggestions that health inequalities were understood in terms of materialist/structural explanations at the turn of the century, the resulting policies suggest that 'lifestyle drift' was very much in operation. Thus, while the primary challenge at this time was reorienting efforts to focus on the root causes of health inequalities, the following decade saw the onset of the global financial crisis which would serve to profoundly undermine all efforts which had sought to level the playing field in relation to both income, and health inequalities. Importantly however, the transformation of the problem of health inequalities has not gone unchallenged and so, what is of particular interest in this thesis, are the *counter-discourses* which emerged in direct response to the different ways in which the problem of health inequalities has been reframed throughout history. In Chapter 3, I introduce the most influential counter-discourse in this field, and I synthesise empirical literature which has examined the extent to which this counter-discourse has operated to shape thinking and practice, and been successful in reorienting action towards the root causes of health inequalities.

CHAPTER 3: NEGOTIATING COUNTER-DISCOURSES

In Chapter 2, I presented a historical account of the different ways in which health inequalities have been problematised in recent history. Of particular importance to this thesis, is the transformation in the problematising of health inequalities from the late 1970s onwards, whereby materialist/structural explanations appear to have been increasingly squeezed out in favour of cultural/behavioural explanations. However, this shift has not gone unchallenged and there now exist a number of established counter-discourses which seek to reorient efforts to work at the root causes of health inequalities. The purpose of this chapter is to provide an account of the empirical literature which has examined the role of discourse, and in particular established counter-discourses, in shaping action to reduce health inequalities. I first introduce the counter-discourse of interest in this thesis, the upstream parable, and detail the relationship between the upstream parable and the highly influential social determinants of health (SDH) discourse. In the main body of the chapter, I provide a synthesis of relevant empirical research and draw particular attention to the challenges of successfully operationalising counter-discourses in practice. I finish the chapter by presenting the specific research aims of the thesis.

3.1.The upstream parable

The counter-discourse at the centre of this thesis is the upstream parable, which emerged in the late 1970s in response to the rising popularity of ideas around individualism and behaviouralism. The parable was first recounted by John B. McKinlay, in his seminal article "A case for refocusing upstream: the political economy of illness":

> There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So, I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing, and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration that I have *no* time to see who the hell is upstream pushing them all in. [emphasis in original]
>
> (McKinlay, 1979, p. 583)

Employing this parable, McKinlay's objective was to highlight the preoccupation in public health with "short-term, problem-specific tinkering", and to call for a

reorientation of efforts upstream to focus on where the "real problems lie" (McKinlay, 1979, p. 583). For McKinlay, the real problems lie with the "manufacturers of illness" (e.g. the food industry) in creating the conditions for health risk behaviours to thrive (McKinlay, 1979, p. 584).

The SDH discourse also emerged around this time, and similarly set out to challenge researchers and practitioners to move beyond the dominant focus on individual risk factors, to consider the range of social factors responsible for the distribution of health across populations (Graham, 2004a). The social determinants of health are perhaps most recognisable in the form of the rainbow model put forward by Dahlgren and Whitehead (2006). Within this model the determinants are presented as concentric layers, with the outer layers representing social determinants such as social and community networks; living and working conditions; and socioeconomic, cultural, and environmental conditions. The upstream parable and the SDH discourse are often treated as synonymous, and indeed the upstream parable is most often used in the context of describing the 'upstream' social determinants of health. It is perhaps for this reason that, when preparing this synthesis of the empirical literature, I did not identify a single study which explicitly set out to examine how people negotiate or interpret the upstream parable itself or the idea of working 'upstream'. As such, the literature presented here focuses on the ways in which the SDH discourse operates to shape thinking and action and reorient efforts to work at the root causes of health inequalities. However, in light of the close relation between the two, there is much to be learned from this literature base about the role of counter-discourses in shaping practice.

3.2.Introducing the literature

It has recently been suggested that, as a consequence of "a growing sense of progress unattained", a new body of empirical literature has been established which focuses on "the way that health inequalities are problematized within policy and practice" (Mackenzie, Hastings, Babbel, Simpson, & Watt, 2017, p. 152). The objective of this body of work is to bring to light confusions, or indeed deliberate misinterpretations, about the nature of health inequalities, and in doing so expose mechanisms which sustain potential discrepancies between rhetoric and action. It is from this body of literature which the studies included in this synthesis have been drawn. I identified relevant studies during my background reading, and through targeted searches and citation tracking. Through these searches, I retrieved studies

from the UK, Canada, and Australia, which included a mix of both discourse analytic work and qualitative studies. In light of the lack of an exhaustive systematic search, and including only articles published in English, there are likely to be studies related to the topic which have not been included in the synthesis. However, the purpose of this chapter is primarily to synthesise the literature most reflective of a UK context, and to also highlight some of the limitations of the evidence base. In doing so, I aim to further demonstrate the rationale for the research questions of the thesis.

The main finding of this synthesis is that despite the influence of counter-discourses within the academic sphere, there are significant barriers to supporting such discourses to gain traction in policy and practice settings. I discuss the literature under three headings, which each illustrate a different challenge. The first section illustrates the role of target setting and performance assessment in operating to actively undermine more long-term goals related to health inequalities. The second section summarises empirical research which has found that the political ideologies and worldviews of frontline practitioners operate most influentially to shape the ways in which they problematise health inequalities, and thus operationalise an SDH discourse in practice. The final section presents findings from two studies which draw attention to some potential limitations of the SDH discourse itself, which may explain in part some of the difficulties in operationalising this discourse in practice.

3.3.Influence of targets and performance assessment

Blackman and colleagues, funded by the Economic and Social Research Council, conducted a qualitative longitudinal study with senior figures within the NHS, local government, and various local partnerships during the implementation of New Labour's health inequalities strategy (Blackman et al., 2009; Blackman et al., 2012; Blackman et al., 2010). Interviews were conducted in 2006 and again in 2008, and sought to examine how different discourses operated to shape stakeholders' conceptualisations of health inequalities, and as a consequence their actions. In light of the newly established targets to reduce inequalities in health by 10% by 2010 (Department of Health, 2002, p. 12), and the strategy of the government to pursue stringent tools of audit and performance assessment, a particular focus of this work was on how such discourses operated to shape action. The authors hypothesised that typical challenges of performance assessment, including "gaming" due to "blame culture", would also be reflected in these new efforts to reduce health inequalities (Blackman et al., 2006, p. 68). Signs to support this hypothesis were evident early in

the study, with the following quote illustrating how the push to meet targets served to undermine intended action on the wider, social determinants of health, in favour of clinical intervention.

> A major push is therefore now underway to achieve the targets by prioritising secondary prevention, such as the use of statins and drugs to reduce hypertension. This approach is one of proactively identifying and treating people on the basis of risk factors like high blood pressure, obesity and smoking. This focus on what is likely to work in the relatively short-term has already biased intervention narratives away from tackling the wider determinants of health inequality, in which local government has an important role, to clinical interventions led by local health bodies.
>
> (Blackman et al., 2006, p. 73)

Interviews with stakeholders would confirm that the targets, and associated performance assessments, had an undue influence in shaping both how stakeholders conceptualised health inequalities, and the nature of action taken to reduce them. One of the primary findings of this study was that the health inequalities targets were not seen to be as politically sensitive compared to targets around access to services and the balancing of budgets. As illustrated in the quote above, when heightened attention was eventually placed on achieving the health inequalities targets, actions tended to be limited to short-term interventions that could provide quick wins. Thus, appropriate action to reduce health inequalities became, for example, ensuring equitable screening and pharmacological intervention for the over 50s (Blackman, 2007). Further qualitative work has corroborated this finding suggesting that, in public health settings, the legacy of the target- and outcome-led culture operates to "distort priorities" thus resulting in the ongoing "marginalisation" of the health inequalities agenda (Orton et al., 2011, p. 8). Blackman et al. (2010, p. 48) also reported that a similar trend was evident in community-based interventions implemented under New Labour, where the performance assessment discourse was found to transform Health Action Zones from autonomous local collaboratives working at the root causes of poor health, into "agents for delivering national priorities". The result was a shift in efforts to targeting lifestyle behaviours and ensuring the uptake of preventative health interventions.

Despite this reorientation in effort, and indeed the limited evidence to support a role for lifestyle interventions in reducing health inequalities, the authors reported finding "a surprising lack of scepticism" amongst interview participants about this approach (Blackman et al., 2009, p. 769). Rather, they found that most interviewees were "focused on the need to improve the health-related lifestyles of people living in

deprived areas" due to the perception that individuals in such areas are traditionally less receptive to lifestyle changes when compared to those living in more affluent areas. The authors outline that while they didn't probe extensively as to why these views were so prominent across the dataset, they speculate that:

> …it is indeed a 'discourse' shaped by government policy documents keen to promote individual responsibility, and by local professional interests keen to be seen to do something about the issue that is plausible, if not actually capable of achieving the change needed.

(Blackman et al., 2010, p. 53)

It is important to highlight that this series of studies is now almost ten years old, and as such perceptions about the drivers of health inequalities, and optimum approaches to tackle them, may have changed. However, despite this, the work provides valuable insight into the ways in which the health inequalities agenda first became fully embedded within health system priorities. Additionally, it was of interest to note the authors' use of 'discourse' in explaining study findings. While the authors don't elaborate fully on their conceptualisation of discourse they do make reference to Foucault's *Archaeology of Knowledge* (Foucault, 1972), and outline that they treated the interviews themselves as discourses and thus as ways of "constructing the world and looking for the rules that establish what is meaningful" (Blackman et al., 2010, p. 48). Later in this same paper, the authors use the term again to illustrate their finding that, in the end, it was not "bodies of evidence" that influenced perspectives and practice, but rather what they describe as "bodies of discourse" which were informed by evidence, but also by the values of stakeholders and indeed resource availability (Blackman et al., 2010, p. 55).

Thus, while the authors may have expected to find greater resistance to the dominant policy discourses at the time, it would appear that audit and performance assessment operated as powerful tools in internalising for stakeholders the 'best' course of action to achieve reductions in health inequalities, as defined by the targets set down from government. Although the authors here alluded to the potential role for political ideology in shaping conceptualisations of health inequalities, we will see in the next section that later research has prioritised this explanation for the challenges in negotiating and operationalising discourses that aim to reorient efforts to work at the root causes of health inequalities.

3.4.Influence of political ideology

Much of the literature which has investigated how stakeholders negotiate counter-discourses in the field of health inequalities, has concluded that the political ideology, not only of governments, but also of individuals, operates to powerfully shape how people problematise health inequalities, and the nature of action that they pursue. In this section I detail the findings of four Canadian studies, which each set out to unpack the relationship between political ideology and the extent to which practitioners engage with an SDH discourse.

A study of particular relevance to the research questions of the thesis is by Raphael (2011), who conducted a discourse analysis of the social determinants of health. The author explains that the rationale for this analysis was their concern, and indeed their exasperation, with the fact that the most influential voices in Canadian health policy are population health researchers, whom Raphael observes as incredibly reluctant to consider the "political and ideological sources of the inequitable distribution" of the social determinants of health (Raphael, 2011, p. 222). It is suggested that the result of this reluctance is that there now exists a variety of SDH discourses which engage with these political and ideological aspects to a greater or lesser extent. It is thus the author's objective to provide an account of these various discourses.

Akin to the work of Blackman and colleagues, Raphael also makes use of the Foucauldian concept of discourse. He rejects the idea that the variations in discourses could be simply put down to differences in Kuhnian paradigms, but rather suggests that they are Foucauldian in the sense that "they involve issues of legitimation, power, and coercion" and thus powerfully influence research and practice (Raphael, 2011, p. 223). The concern for Raphael is that some discourses, particularly those that are less politically contentious, seem to be gaining greater traction in Canada, over and above those which seek to challenge the status quo and the structural drivers of health inequalities. He further justifies this approach in outlining:

> The reason why I raise the Foucaultian concept of discourse is that these SDH discourses appear to direct the kinds of research and professional activities that are deemed acceptable, i.e. fundable in the case of research and institutional budgeting, and career-enhancing in terms of personal futures. The result is that there are just a handful of Canadian health researchers and workers who write and talk publicly about the economic and political forces that shape the quality of the SDH.
>
> (Raphael, 2011, p. 223)

However, this is the extent of the detail provided by the author as to how he has employed a Foucauldian lens in the work. While the title of the publication is "A discourse analysis of the social determinants of health", no methodology section is provided to illustrate the type of discourse analysis employed, or the author's approach to conducting the analysis. Rather, the text reads as the author's own reflections on the different perspectives encountered in their own research and practice. However, despite this shortcoming of the work, and in light of its relevance to the thesis, I have opted to reproduce in full the SDH discourses identified in this study (Table 2).

As shown in Table 2, Raphael (2011) identified seven SDH discourses. While not explicitly organised into system levels, there is a pattern whereby discourses 1 and 2 are actions which take place at an individual level, moving up to the latter discourses, and in particular discourses 5, 6 and 7, which involve action at the level of political and economic structures. In light of the lack of methodological detail in the study, it is unclear what resources were drawn upon to produce this list of discourses. It is however my personal reflection, from my understanding of the model of the social determinants of health, that some of the discourses may be more reflective of general perspectives around how we can work to improve health and reduce health inequalities, as opposed to being specifically attuned to the social determinants concept. Nevertheless, these discourses usefully illustrate an approach to stratifying the component parts of a counter-discourse in the field of health inequalities. And indeed, a number of authors have since employed these discourses to distinguish the nature of actions with which different stakeholders and organisations engage.

Table 2. Social determinants of health (SDH) discourses (Raphael, 2011)

	SDH discourse	Key concept	Dominant research and practice paradigms	Practical implications of the discourse
1	SDH as identifying those in need of health and social services	Health and social services should be responsive to people's material living circumstances	Develop and evaluate services for those experiencing adverse living conditions	Focus limited to service provision with assumption that this will improve health
2	SDH as identifying those with modifiable medical and behavioral risk factors	Health behaviors (e.g. alcohol and tobacco use, physical activity and diet) are shaped by living circumstances	Develop and evaluate lifestyle programming that targets individuals experiencing adverse living conditions	Focus limited to health behaviors with assumption that targeting for behavior change will improve health
3	SDH as indicating the material living conditions that shape health	Material living conditions operating through various pathways – including biological – shape health	Identify the processes by which adverse living conditions come to determine health	Identifying SDH pathways and processes reinforce concept and strengthen evidence base
4	SDH as indicating material living circumstances that differ as a function of group membership	Material living conditions systematically differ among those in various social locations such as class, disability status, gender, and race	Carry out class-, race-, and gender-based analysis of differing living conditions and their health-related effects	Providing evidence of systematic differences in life experiences among citizen groups form the basis for further anti-discrimination efforts
5	SDH and their distribution as results of public policy decisions made by governments and other societal institutions	Public policy analysis and examination of the role of politics should form the basis of SDH analysis and advocacy efforts	Carry out analyses of how public policy decisions are made and how these decisions impact health (i.e. health impact analysis)	Attention is directed towards governmental policymaking as the source of social and health inequalities and the role of politics
6	SDH and their distribution result from economic and political structures and justifying ideologies	Public policy that shapes the SDH reflects the operation of jurisdictional economic and political systems	Identify how the political economy of a nation fosters particular approaches to addressing the SDH	Political and economic structures that need to be modified in support of the SDH are identified
7	SDH and their distribution result from the power and influence of those who create and benefit from health and social inequalities	Specific classes and interests both create and benefit from the existence of social and health inequalities	Research and advocacy efforts should identify how imbalances in power and influence can be confronted and defeated	Identifying the classes and interests who benefit from social and health inequalities mobilizes efforts towards change

Brassolotto, Raphael, and Baldeo (2014) for example, conducted a qualitative study with 18 Medical Officers of Health and lead staff from nine Ontario Public Health Units (PHUs) to examine differences in the extent to which these units addressed the social determinants of health. The authors also sought to provide some explanation for how these differences came about. Interestingly, up front, the authors outlined their theory as to why there might be varying levels of engagement with action on the social determinants of health:

> We carried out this study to examine our assumption that there might be epistemological challenges to PHUs applying these concepts. To explore this, we sought to understand the worldviews of public health officials concerning these issues.
>
> (Brassolotto et al., 2014, p. 2)

The epistemological challenges that the authors had in mind were barriers resulting from particular conceptualisations of health and society, and perspectives on the roles and responsibilities of the public health community. While also citing Foucault in the background section of the text, no further details are provided as to how a Foucauldian lens was employed in the analysis. Additionally, while the questions are described as being designed to elicit participants' constructions of the social determinants of health, no interview schedule is provided to illustrate the nature of the questions asked. Nevertheless, the authors provide a detailed account of the interview data, which found that the PHUs conceptualised the social determinants of health in three distinct, yet overlapping ways. Using the typology of SDH discourses (Table 2), the authors found that three units could be categorised as functional, four units as analytic, and two units as structural in nature. Perhaps unsurprisingly these categorisations were found to "map nicely onto Raphael's (2011) SDH typology" (Brassolotto et al., 2014, p. 5) where functional units drew on discourses 1 and 2, analytic units drew on discourses 3 and 4, and structural units drew on discourses 5-7. Thus, with just two units employing a structural approach to engaging with the social determinants of health, the authors found that they were able to validate their assumptions at the outset, and concluded that units categorised as functional or analytic faced epistemological barriers to engaging in a more structural approach to address the social determinants of health. These epistemological challenges were attributed to biomedical understandings of health amongst professionals, along with the "internalisation" of dominant discourses which treat health as "individualized and depoliticized" (Brassolotto et al., 2014, p. 1).

These authors went on to publish further analyses from what appears to be the same dataset. In this second paper the PHUs are categorised by three *clusters of action*: (1) service

delivery oriented, (2) intersectoral and community based, and (3) public policy/public education-focused (Raphael, Brassolotto, & Baldeo, 2014). The differences in approach are this time attributed to the ideological commitments held by staff, along with organisational infrastructure to support action to address the social determinants of health. While important and relevant texts in the context of this study, the lack of detail provided on the analytic steps, and indeed the emphasis placed by the authors on the role of *ideology* in shaping practice, call into question how consistent such studies are with a Foucauldian perspective. As described in Chapter 1, Foucault rejects the notion of ideology as it presupposes the existence of an independent and knowable truth. Rather, a Foucauldian inspired analysis seeks to bring to light, not the effects of ideology in shaping perspectives and action, but rather *how* power-knowledge relations, facilitated through discourse, result in some constructions of a problem becoming elevated to the status of truth at any given point in time. However, despite such limitations, this literature provides important insights into the challenges of operationalising counter-discourses in practice.

Two further Canadian studies which set out to illustrate the relationship between political ideology and engagement with the social determinants of health (SDOH) discourses were Collins (2012), and McIntyre, Shyleyko, Nicholson, Beanlands, and McLaren (2013). The study by Collins (2012, p. 374) employed a survey design methodology to "assess the relationship between participants' SDOH-related perceptions with their values and political orientations". The survey questions asked respondents to rank determinants of health in order of influence, and also rank priorities for action. Participants were found to assign high levels of influence to "healthy lifestyles" and "clean air and water", and similarly assigned the highest priority to both. The lowest priority was assigned to "income" which prompted the authors to conclude that "individualistic views about responsibility for health are deeply engrained in the psyches of Canadians", something which is described by the authors as both "disconcerting" and "worrisome" in light of the established role of socioeconomic status in shaping health (Collins, 2012, p. 279). The authors propose two possible explanations for the study findings. Firstly, they suggest that while participants may be aware of the influence of the wider determinants on health, they may not feel responsible or empowered to improve them. And secondly, not unlike Brassolotto et al. (2014) and Raphael et al. (2014), the authors hypothesised that participants viewed healthy lifestyles as being the responsibility of individuals "as reflected in neo-liberal discourse and ideology" so prominent in Canada at the time of the research (Collins, 2012, p. 380).

A final study, by McIntyre et al. (2013), reported similar findings in an investigation of the ways in which public health workers and youth advocacy workers problematised the social

determinants of health. Unlike the earlier texts discussed, the authors here did provide the interview schedule for their study, a schedule which was amended between the two sets of group interviews. The first set of interview questions are shown below:

> (1) How would you describe to a layperson what the SDOH framework is, and what types of actions might be taken on the social determinants of health to reduce health inequalities?
> (2) Imagine a thoughtful person who rejects the SDOH notion – what would they say to those immersed in the SDOH paradigm, and what would they be most likely to argue against?
> (3) Identify the cleavage issues (philosophical, value-based) as well as the information deficits between the two views.
>
> (McIntyre et al., 2013, p. 4)

From these questions it is evident that, not unlike Brassolotto et al. (2014) and Raphael et al. (2014), McIntyre et al. (2013) also hypothesised that different perspectives on the social determinants of health could be explained by an individual's worldview and personal philosophy. However, following the first round of data collection the authors reflected that, as the questions presupposed what participants may think, a more "neutral" set of questions needed to be devised (McIntyre et al., 2013, p. 5). Interestingly, while the authors ultimately did find differing views on the social determinants of health, participants considered these to be more reflective of "shades of grey rather than polarized paradigmatic views", and were reportedly reluctant to "'demonize' those who might oppose the SDOH framework", something which was seen as unnecessarily "divisive" (McIntyre et al., 2013, p. 5). Additionally, while participants were found to have difficulty in moving beyond individual level actions to improve health, this was explained as a consequence of feeling overwhelmed about what they could do from within their professional roles to address the social determinants of health. This feeling of being overwhelmed was attributed in particular to the recommendation put forward within the report from the Commission on Social Determinants of Health, which goes beyond calls for action within particular social domains, to recommending action to reduce the inequitable distribution of power, wealth, and resources in society (Marmot, Friel, Bell, Houweling, & Taylor, 2008).

In summary, the main findings of these studies suggest that despite the apparent influence of the SDH discourse within an academic sphere, there exist numerous barriers to operationalising this discourse in practice. The most notable barrier identified by authors here has been oriented around the worldviews of practitioners who are said to have internalised neoliberal discourses espousing individual responsibility for health. Additionally, authors suggest that practitioners may feel overwhelmed, and thus feel unable to negotiate a path to engaging in more structural aspects of the discourse (e.g. discourses

5-7 in Table 2). There are, however, some notable shortcomings of this evidence base which should be considered in future research of this nature. Firstly, there is lack of methodological clarity across the studies especially in terms of theoretical approaches and data collection procedures (e.g. provision of interview schedules). Secondly, there also appears to be a level of circular reasoning apparent in the studies whereby authors have set out to demonstrate the role of worldviews and political ideology in shaping constructions of the SDH discourse, and have ended up finding just that. While not disputing these findings, improved reporting of methods would provide the added context needed to make a more robust and informed assessment of what could be argued to be a rather reductionist explanation for such a complex issue.

That said however, a recent qualitative study in the UK, which took a slightly different perspective, did indeed find epistemological differences to the problem of health inequalities amongst researchers (Garthwaite, Smith, Bambra, & Pearce, 2016). Three categories of researcher were identified: (1) policy-focused positivists, (2) empathetic ethnographers, and (3) critical materialists. Policy-focused positivists espoused the need for more robust quantitative experimental designs to produce policy relevant knowledge. In contrast, empathetic ethnographers stressed the need for qualitative research with individuals and communities facing the brunt of health inequalities, to capture the complexity of everyday experiences. And lastly, critical materialists advocated for increased attention to be paid to the mechanisms through which society is becoming increasing more inequitable. The authors of the studies presented above perhaps best align to this category of critical materialists. In contrast to the earlier studies discussed, Garthwaite et al. (2016) conclude that rather than pitting these three perspectives against one another, the health inequalities research community may be better served by creating space for each of these perspectives to contribute in their own ways to tackling the problem of health inequalities. A similar reflection has previously been shared by Hawe (2009, p. 290), who suggested that "the way forward is not for academics to berate lifestyle risk factor-focussed practitioners for not working directly on the SDOH" but rather what is needed is additional support for practitioners "to reframe their work in ways that connect more strongly" with the social determinants of health.

3.5.Challenges of the social determinants of health discourse

A recent study by Mackenzie et al. (2017) sought to do just as Hawe (2009) has recommended, and find an approach that could unpack and challenge how practitioners problematise health inequalities. The particular focus of this study was to explore

practitioners' perspectives on how differential health outcomes might arise from four policy scenarios: (1) a geographically targeted screening programme, (2) redistribution of general practitioners (GPs) by socio-economic need, (3) increased availability of free child care, and (4) Living Wage policies. The authors used a 'talk and draw' method based on the visual graphics employed by Benach, Malmusi, Yasui, and Martínez (2013) in their typology of policies to reduce health inequalities. Participants were encouraged to illustrate their perceptions of the likely effects of the four different policies on the health outcomes of the highest, middle, and lowest socioeconomic groups. The rationale for using such an approach was to unsettle or "penetrate" what the authors perceived to be "well-rehearsed discourses" around health inequalities (Mackenzie et al., 2017, p. 151). The authors also employed the typology of SDH discourses proposed by Raphael (2011), and found that while participants employed both material and behavioural explanations for health inequalities, they did not explicitly engage with "the political roots of material disadvantage" (Mackenzie et al., 2017, p. 168). This research group identified similar findings in their study exploring the engagement of GPs in action to reduce health inequalities. Using the same typology of SDH discourses, the authors suggest that while small number of GPs employed discourses reflective of a structural approach to reducing health inequalities, that further work was needed to develop these insights in GPs working in disadvantaged areas (Babbel, Mackenzie, Hastings, & Watt, 2017). This challenge of operationalising the social determinants model has been previously highlighted. Krieger, Dorling, and McCartney (2012), for example, suggested that while the rainbow model includes socioeconomic, cultural, and environmental conditions, the need to consider the political economy which shapes the *distribution* of these determinants is not explicit within the model. Indeed, Dahlgren and Whitehead (2006) in their seminal World Health Organisation (WHO) report make a clear distinction between the determinants of health, and the determinants of social inequities in health. Rather than a list of factors, the latter brings into the frame consideration of different levels of power and resources; different levels of exposures to health hazards; differential impacts of the same exposures; life-course effects; and the social and economic impacts of being sick. It would seem that rather than the social determinants of health, it is the determinants of social inequities in health that the authors of the studies included here are most eager to see articulated amongst frontline practitioners.

One final study which merits discussion, and again provides a slightly different take, is from Fran Baum and her examination of former Australian Health Ministers' perspectives on the social determinants of health (Baum, Laris, Fisher, Newman, & MacDougall, 2013). Of particular interest in this study are the similarities in the challenges experienced in

operationalising the SDH discourse. Unsurprisingly, in light of the study sample, political leanings were identified as highly influential in shaping how participants problematised health inequalities and action to address their social determinants. However, participants themselves also highlighted what they perceived to be the ideological nature of much public health research. They suggested that one of the primary difficulties in implementing public health recommendations was that they were often oriented towards radical change of political philosophy (i.e. a move to social democracy), rather than a more pragmatic approach seen to be both more feasible and contextually appropriate for the Australian setting. Additionally, reflective of findings from Collins (2012) and McIntyre et al. (2013), the Ministers described that despite the rhetoric of cross-government working, and whole of government approaches, often they felt they were lobbied on things over which they had limited power to act. As a consequence, Ministers tended to focus on changes over which they had some control, most notably ensuring equitable access and uptake of health services. Thus, despite the popularity and widespread influence of the SDH discourse, there appears to be a number of challenges to operationalising this counter-discourse in practice, and thus reorienting efforts to work at the root causes of health inequalities.

3.6.Chapter summary and research aims

The purpose of this chapter has been to provide the academic context for the thesis and to synthesise relevant empirical literature which has examined the role of discourse, and in particular counter-discourses, in shaping how people make sense of, and work to reduce health inequalities. As outlined at the outset of the chapter, I did not identify any empirical research which sought to explicitly examine how different actors negotiate and interpret the upstream parable or the idea of working 'upstream'. As such the literature synthesised here focuses on the challenges of operationalising the SDH discourse. The primary challenge, perhaps unsurprisingly, is the power and influence of dominant and pervasive discourses (e.g. neoliberal and performance assessment discourses) which continue to drive action 'downstream', with a resulting focus on quick wins at an individual level. This empirical evidence, of the ongoing difficulty in reorienting thinking and action to work at the root causes of health inequalities, is reflective both of the theoretical debates outlined in the Introduction to the thesis, and the political transformation of the problem discussed in Chapter 2.

As such, there is a gap in our knowledge about the potential utility and effectiveness of alternative counter-discourses in supporting researchers and practitioners to realign their thinking and action to work at the root causes of health inequalities. The counter-discourse

of interest in this study is the upstream parable, and it is currently unknown how researchers and practitioners who are working to reduce health inequalities negotiate and interpret the parable in their work. While the upstream parable and the social determinants of health are often treated as synonymous in the context of explaining the determinants of health, there are likely to be important differences when employing the respective discourses in theorising *action* to reduce health inequalities. Additionally, while much has been written about the upstream parable, or as I have come to treat it in this thesis, the upstream counter-discourse, there does not yet exist an in-depth analysis of this discourse to examine how it is intended to operate in practice, and indeed the nature of *action* advocated through use of the parable. As such, the two research questions which I set out to answer in the thesis were:

1. How is the idea of working 'upstream' articulated in the academic literature?
2. How is the upstream parable interpreted by a sample of people working to reduce health inequalities?

In answering these questions, the objective of the thesis is to generate new insights about how counter-discourses operate in practice, and in doing so, to contribute to closing this gap in our knowledge. I also aim to bring to light any sticking points in operationalising the counter-discourse, with a view to making recommendations as to how these may be fruitfully addressed in order to better support people to reorient their efforts to work at the root causes of health inequalities.

CHAPTER 4: METHODOLOGY & INTERPRETATION

In Chapter 3, I synthesised empirical literature which sought to examine how discourses operate to shape the thinking and actions of those working to reduce health inequalities. I highlighted a particular gap in our knowledge in relation to a counter-discourse in this field, the upstream parable. While often employed in discussions around the determinants of health, it has been suggested that in more recent times the idea of working 'upstream' has evolved "from parable to concept, noun to adjective, and ideal to strategy" (Butterfield, 2017, p. 3). Employing discourse analysis methodology in this study, I aim to examine this *strategy* of working 'upstream' and answer two questions: (1) how is the idea of working 'upstream' articulated in the academic literature, and (2) how is the upstream parable interpreted by a sample of people working to reduce health inequalities?

In Chapter 1, I provided a detailed account of the theoretical perspective employed in the thesis, and so the purpose of this chapter is to detail the methodological steps taken in collating the datasets for the study, and conducting a discourse analysis. I open the chapter with a brief overview of the wider intellectual backdrop against which the ideas of Michel Foucault gained traction, and which also resulted in a growing interest in the role of language and discourse in playing a powerful role in shaping our day-to-day realities. I then introduce the particular variant of discourse analysis employed in this thesis, and distinguish it from other prominent approaches. The sections which follow detail the processes involved in constructing two datasets for the study, along with a detailed account of my approach to the analysis. I conclude the chapter with some reflections on the approach, and some important considerations for interpreting the study findings.

4.1.Social constructionism and the 'turn to language'

The ideas of Michel Foucault emerged against a backdrop of a number of influential shifts in Western philosophical thought. Within this section I concentrate on the rise in influence of social constructionist thought, and the resulting "turn to language" (Willig, 2013a, p. 338). These shifts were closely related to what has been described as the "crisis in social psychology" (Burr, 2015, p. 16), an event which illustrates the ways in which previously established 'truths' and modes of knowledge production began to be called into question. Reflective of the power-knowledge relation discussed in Chapter 1, the crisis in social psychology was instigated by concerns that the discipline was becoming increasingly entwined with a political project during the Second World War, where knowledge was explicitly produced to meet the needs of the American and British governments.

Additionally, epistemological tensions within the discipline were becoming more pronounced with the introduction of new investigative techniques, such as brain chemistry and imaging. This resulted in the field of social psychology becoming increasingly aligned with a positivist paradigm and the search for biological and reductionist explanations for psychological phenomena, an approach which was in direct opposition to the views of emerging subgroups of the discipline (Burr, 2015).

Burr (2015) highlights two texts as particularly influential in driving the social constructionist movement in the field of social psychology, *The Social Construction of Realit*y (Berger & Luckmann, 1966), and "Social psychology as history" (Gergen, 1973). The objective of both texts was to challenge the prevailing perspective that language acts as a window into reality, and instead suggest that it is through language that people come to construct reality. Extending this perspective, Burr (2015) describes four tenets of the social constructionist perspective, which are closely related to the ideas of Michel Foucault discussed in Chapter 1. The first tenet of social constructionism is a questioning of taken-for-granted knowledge. Taking gender as an example, this perspective questions the self-evident and proposed 'naturalness' of the categories of male and female and in doing so highlights that, despite accepted biological differences, in many ways these categorisations are social constructs which operate to shape realities about what it means to be male or female.

Secondly, social constructionism stresses the historical and cultural specificity of knowledge. The approach challenges the idea that the way people think, feel, and act is in some way pre-wired into their make-up and reflective of universal laws of human nature. Rather, a social constructionist perspective proposes that how we come to understand the world is reflective of knowledges and systems of thought which are particular to different time points and cultures. This stance thus challenges the pervasive idea in Western thought that through our dominant, scientific mode of knowledge production we have identified universal laws of human nature, which, in what Burr describes as a form of "intellectual imperialism", are then mistakenly imposed on other cultures and nations (Burr, 2015, p. 4). The two final tenets of social constructionism are closely related and are oriented around the idea that rather than knowledge being produced through observation of the natural world, it is constructed in the daily interactions between people. From this perspective, rather than simply considering language as a mode of communication, social constructionists view language as having an action orientation where, within daily interactions, the ways in which concepts and systems of thought are used, have important implications for knowledge and social action.

As a result of this particular view of knowledge, the ensuing 'turn to language' is perhaps unsurprising. Indeed, developments in the study of language have, in recent years, resulted in what Hook (2001) describes as a "growth industry" in discourse analysis. The phrase 'discourse analysis' can refer to a multitude of different approaches, which vary in their focus and their objectives, in the claims they aim to make, and in the nature of the tools and techniques they employ (Hammersley, 1997, p. 237). Two particular forms of discourse analysis are said to have emerged specifically from the crisis in social psychology and are categorised as a discursive psychology approach, and Foucauldian discourse analysis (FDA). I will discuss each in turn, highlighting the difference in focus of the two approaches, and in doing so illustrate the rationale for employing FDA to answer the questions set out in this thesis.

4.2. Discourse analysis

Pioneers of the discursive psychology approach are Jonathan Potter and Margaret Wetherell, who provided a compelling critique of the cognitivism of social psychology, and set out a methodological alternative to the experiments and questionnaires that had dominated research practice (Potter & Wetherell, 1987). Their discursive psychology approach focuses on the ways in which individuals negotiate meaning in everyday social interactions (Wiggins & Potter, 2011). Additionally, this approach is interested in the ways in which language is used in a performative way, in the construction of social accounts to achieve a goal or construct a particular identity (Burr, 2015, p. 19). In contrast to other discourse analytic approaches, discursive psychology is best suited to analysing naturally occurring speech or interaction (Willig, 2013a). The reason being that with data derived through formal research interviews, the focus of the analysis can become more oriented towards the performative function of language in managing the interviewee's stake in the interview process and the study, rather than on the research objectives themselves (Willig, 2013a, p. 348). As such, discourse analyses from a discursive psychology perspective tend to favour data derived from, for example, professional consultations.

In analysing such consultations, the objective is to understand how participants employ discourse to achieve a particular objective. For example, a parent might draw on particular medical or pathological discourses to position their child as distinctly different from other children of the same age, and thus requiring some form of attention or intervention. If parents are suitably privy to the required medical discourses, they may employ particular words or expressions that would ensure that their account of their child's development or behaviour meets the criteria or requirements for a diagnosis, and as a consequence referral

for more robust intervention. Similarly, asylum seekers, for example, may employ particular discursive resources to ensure that accounts of their experiences are reflective of the institutional requirements to achieve the status of asylum seeker. Thus, the approach seeks to examine simultaneously how people employ discursive resources to bring about a social action, and illustrate the power interplays of institutional norms, and practices, and these discursive resources. Burr (2015, pp. 24-25) helpfully categorises this approach as "micro social constructionism" due to the focus on the localised use of discourse, in contrast to the "macro social constructionism" of Foucauldian inspired approaches.

A Foucauldian approach to discourse analysis takes a slightly different perspective, and aims to examine the ways in which problems are constructed through discourses, and, as a consequence, the ways in which people are constituted as particular types of subjects. While reflective of the principles of social constructionism described in Section 4.1, Foucault's later work has resulted in him being most often described as a poststructuralist. Structuralism and poststructuralism have heavily influenced the study of language, and so here I will briefly describe the two perspectives while also illustrating the relation between poststructuralist ideas and social constructionism. Of particular importance here is the work of structuralist and linguist Ferdinand de Saussure (1857-1913). From a linguistics perspective, the underpinning principle of structuralism is that concepts can only be recognised and understood through their relation to other concepts within an overarching structure of language. However, some notable findings from de Saussure's study of structural linguistics (de Saussure, 1974), resulted in a questioning of the idea that there does exist a universal structure of language. For example, de Saussure illustrated the arbitrary nature of concepts which are not consistent across languages. As a consequence it is not always possible to produce exact translations of speech or texts due to concepts existing in some languages which do not appear in others (Burr, 2015, p. 59). Additionally, de Saussure suggested that for languages to function concepts must become 'fixed' so that everybody is using the same concept to describe the same thing. While perhaps the case for many concepts in a language, this latter point cannot be said to be true for all, as some concepts have had their meaning changed over time. Burr (2015, p. 61) uses the example of the word "gay", which has in the past been used to describe someone as "happy and joyful" but is now predominantly used to describe people who have same-sex relationships. Thus, poststructuralism, like social constructionism, rejects the idea that language follows an ordered structure and can thus act as a mirror into reality. Rather than focusing on the concepts themselves, both perspectives are attuned to the historical and cultural specificity of language, and are interested in the conditions which give rise to different concepts and language, and their relationship to reality and social action.

In summarising the distinction between the two approaches to discourse analysis, Willig (2013a, p. 344) outlines that:

> While discursive psychology is primarily concerned with *how* people *use* discursive resources in order to achieve interpersonal objectives in social interaction, Foucauldian discourse analysis focuses upon *what kind of* objects and subjects are constructed through discourses and *what kinds of* ways-of-being these objects and subjects make available to people. (emphasis in original)

Some authors have made the case for combining approaches within a single study (Wetherell, 1998), which would allow for dual analysis of the micro, and macro, levels of social constructionism (Burr, 2015, pp. 24-25). However, the aims of this thesis were specifically oriented towards understanding how the upstream counter-discourse operates to shape problematisations of health inequalities, and, as a consequence, shapes implications for action. As such, I opted to employ a purely FDA approach that, as Willig (2013b) outlines above, would allow for analysis of the kinds of objects and subjects constructed through discourse. To answer the research questions of the thesis, two different datasets would be required.

4.3.Constructing the datasets

Willig (2013b, p. 382) advises that the selection of texts be informed by the research aims. The aims of this study were to examine (1) how the idea of working 'upstream' is articulated in the academic literature, and (2) how the upstream parable is interpreted by a sample of people working to reduce health inequalities. Thus, the two different datasets constructed for use in the study were: (1) a sample of academic texts, and (2) a sample of semi-structured interviews. In the sections that follow, I first describe the procedures involved in constructing the datasets, before dedicating Section 4.4 to detailing the step-wise approach to applying the method of FDA to the datasets.

4.3.1.Sample of academic texts

The first aim of the thesis resulted from my observation that while people regularly employ the language of the upstream parable, or as I have come to treat it, the upstream counter-discourse, there does not yet exist an in-depth analysis of the discourse which examines how it is intended to operate in practice, and indeed the nature of *action* advocated through use of the parable. The first step in constructing a sample of academic texts for analysis involved identifying and collating texts from my background reading which had made reference to the language of 'upstream', or the upstream parable, in describing action to reduce health inequalities. As I became familiar with these texts, it quickly became evident

to me that a systematic database search may prove challenging. The most notable challenge was the volume of texts using the language of 'upstream' in the context of describing the determinants of health alone, without any further explication about what this could or should entail. As such, I first worked with the texts identified in my early background reading to get a feel for the content, and develop some preliminary inclusion and exclusion criteria for the dataset. The criteria set at this stage were that texts must: (1) be a peer-reviewed journal article, (2) be orientated around action to reduce health inequalities, and (3) use the upstream parable or the language of 'upstream' in some form beyond describing or labelling determinants of health. Texts had to demonstrate some consideration of health inequalities and I was inclusive of different expressions e.g. inequities, disparities. Texts which only discussed social and economic inequality, without relating these to health inequalities in some way, were not included in the final dataset.

Through my background reading, which also involved citation tracking, I identified 17 texts that could contribute to the study aims. In a number of cases it was necessary to apply the analytic steps to the texts to fully assess the extent to which they could contribute to the analysis. For example, a number of texts which on first reading seemed relevant to the study, when put under the scrutiny of the analytic framework were actually much lighter on detail than first perceived. As such, deciding on whether or not to include texts in the final analysis was an iterative process of trialling the analytic framework and making a subjective assessment about the extent to which individual texts could contribute to the study aims.

Despite there being a wealth of data in these 17 texts, I was however concerned that by relying on these more highly cited and easily accessible texts, I may be limiting myself to more niche pockets of the academic literature. I therefore decided to supplement the texts identified during my background reading with a tight database search to identify additional potentially relevant texts. As outlined, the volume of texts which employ the language of 'upstream', but without the required level of theorisation or explanation meant that it would be inappropriate to rely on screening of titles and abstracts alone. To assess the extent to which citations met the inclusion criteria for the study, and could contribute to the study aims, I would need to consult the full texts. Thus, to manage the number of citations retrieved I used a simple search string ((inequalit* [Title/Abstract] OR inequit* [Title/Abstract] OR equit*[Title/Abstract])) AND upstream [Title/Abstract])) in a single electronic database (PubMed) and limited the publication date from the year 2000 to the date of the search (25th of July 2017). The search resulted in 116 citations. I downloaded the titles and abstracts for each citation into a word document and first removed any

citations that were clearly not relevant to the study objectives. I retrieved the full texts of all of the remaining citations and applied the inclusion criteria. Through this systematic search I identified a further 15 studies that could contribute to the objectives of the analysis. An overview of the final included texts is provided in Table 3. Further details on the individual texts included in the analysis are provided in Table 5 presented at the outset of Chapter 5. Potential limitations of this approach to selecting texts are discussed in Section 4.5.3.

Table 3. Overview of included texts

Identified through:	**n**
Scoping searches	17
PubMed search	15
Year of publication:	n
1996-2001	2
2002-2010	7
2011-2017	23
Journal:	n
Advances in Nursing Science	2
American Journal of Public Health	4
BMC Public Health	4
BMJ Open	1
Community Dentistry and Oral Epidemiology	1
European Journal of Public Health	1
Global Health Promotion	1
Health Care for Women International	1
Health Education and Behaviour	1
International Journal for Equity in Health	1
Journal of Dentistry	1
Journal of Eating Disorders	1
Journal of Epidemiology and Community Health	2
Journal of Public Health	2
Journal of Public Health Nursing	1
Maternal and Child Health Journal	2
Oral Diseases	1
Revista Brasileira de Epidemiologia	1
Social Science & Medicine	1
South African Review of Sociology	1
Systematic Reviews	1
The Lancet	1
The Milbank Quarterly	1
Source type:	n
Commentary	4
Conceptual framework article	2
Discussion article	11
Editorial	2
Empirical research	4
Methodological article	2
Protocol for an umbrella review	1
Rapid overview of reviews	1
Review article	2
Systematic review	2
Workshop report	1

4.3.2.Semi-structured interviews

To meet the second study aim, an additional dataset was constructed through semi-structured interviews with people working to reduce health inequalities. The aim of the interviews was to examine how people interpret and make sense of the upstream parable in the context of reducing health inequalities, and examine the extent to which ideas which underpin an academic account of the counter-discourse have translated into the day-to-day practices of participants. While naturally occurring talk is the preferred form of data for a discourse analysis premised on discursive psychology, data from semi-structured interviews have been identified as appropriate for use in FDA (Willig, 2013b, p. 383). Additionally, Willig (2013b, p. 383) advises that the use of multiple datasets, as employed in this study, allows for consideration of the relationship between "public or expert discourses and the ways in which lay people take up (and possibly transform) such discourses".

As outlined in the introduction to the thesis, the motivation for this study stemmed from my observations that there existed real tensions for professionals in negotiating how best to contribute to reducing health inequalities when they were themselves often situated within frontline services. Additionally, for clinicians like myself, there is the particular challenge in moving beyond clinically driven perspectives, to more fully understand the socially driven problem of health inequalities. As I became increasingly familiar with the nature of action advocated by those employing the language of 'upstream' and the upstream parable in the academic literature, the implications of these difficulties was increasingly clear. As such, in the second part of this study, I set out to explore in-depth how individuals, who were linked into the work of the collaboration in various different ways, came to understand the problem of health inequalities and how they negotiated their role in contributing to reducing them. While there would certainly be a case for examining the thinking and actions of those in senior policy- and decision-making roles, I was particularly interested in understanding how those closer to the frontline were reacting to effectively having had a health inequalities agenda thrust upon them, and their work. Thus, while the collaboration provided a convenient sample, it also provided a truly novel and unique sample of individuals who, along with the organisations that they represented, had various degrees of interest, insight, and experience of working to reduce health inequalities. The rationale for selecting the collaboration as a case was consequently to avoid a sense of 'preaching to the choir', and rather take advantage of the opportunity to speak to a unique disciplinary mix of individuals (i.e. academics, NHS clinicians, local authority practitioners, those from third sector organisations, public advisors) who, like myself, were in the process of getting to grips with this problem of health inequalities while

simultaneously navigating their own expectations, those of the collaboration, and indeed those of their own organisations.

In the sections that follow I describe in greater detail the procedures for identifying participants, conducting the interviews, and preparing the interview data for analysis.

Sampling and method of approach

Prior to entering the field, I first obtained ethical approval from the University of Central Lancashire's Science, Technology, Engineering, Medicine and Health committee (Ethics number: STEMH573) (see Appendices A-G). I employed a purposive sampling strategy to ensure that a diverse mix of participants were represented in the study sample. For example, I sought to recruit to the study a range of researchers, practitioners, and public advisors working across health service settings, local authority organisations, and third sector partners. To identify potential participants for the study I used a combination of:

1) contacting people known to me within the collaboration and inviting them both to participate in the study and share the details of the study with their contacts within the organisation
2) snowball sampling where participants would pass on the details of the study to other people who they knew within the collaboration who might take part
3) through attending different events organised by the collaboration and sharing the details of my study
4) through attending a public reference panel event and inviting panel members to take part.

The email invite and study information sheets are provided in Appendices B, C, and D. As I do not know how many people will have received the information sheet for the study through the snowball sampling approach, it is not possible to determine the total number of people who will have been invited in some way to participate. In total, 18 people took part in a semi-structured interview and their characteristics are shown in Table 4 below.

In recent years, there has been a growing emphasis placed on the importance of ensuring adequate representation and involvement from patients and members of the public to inform applied health research. From the outset, public advisors have been an integral component of the collaboration, both through the newly established Public Reference Panel, and through their involvement in funded projects. As a consequence of this established role within the collaboration, I felt that it was important to also capture views and insights of public advisors in this study. As shown in Table 4, the sample comprised

four core staff of the collaboration, four public advisors, four postgraduate research students, and six partners from across the NHS, local authority, and third sector organisations. Thirteen participants were female and five were male, three of whom were public advisors. Four participants were either currently working as healthcare professionals (HCPs) or had previously trained and worked as a healthcare professional. Half of the sample were not known to me at all prior to the interview. I knew five participants prior to the interviews, and four of the participants I knew well. To protect the confidentiality of interview participants I have opted not to attribute participant's contributions to their details provided in Table 4 (i.e. gender, work setting, background). The pool of participants from which the sample was drawn is small, and some participants would be well-known locally because of the prominence of the collaboration in the region in recent years. However, as context is important in interpreting participants' insights, I have provided some additional details in Table 15 presented at the outset of Chapter 6.

Table 4. Sample characteristics

Role	Gender	Work setting	Background	Relationship to me
Core staff	Female	University	Non-HCP*	Well-known
Core staff	Female	University	Non-HCP	Known
Core staff	Female	University	Non-HCP	Not known
Core staff	Female	University	Non-HCP	Known
Public Advisor	Male	n/a	Non-HCP	Known
Public Advisor	Male	n/a	Non-HCP	Not known
Public Advisor	Female	n/a	HCP	Not known
Public Advisor	Male	n/a	Non-HCP	Not known
Postgraduate student	Female	University	Non-HCP	Well-known
Postgraduate student	Male	University	Non-HCP	Known
Postgraduate student	Female	University	HCP	Known
Postgraduate student	Female	University	HCP	Well-known
Practitioner	Female	NHS	Non-HCP	Not known
Practitioner	Female	NHS	HCP	Well-known
Practitioner	Male	Local authority	Non-HCP	Not known
Practitioner	Female	Local authority	Non-HCP	Not known
Practitioner	Female	Third sector	Non-HCP	Not known
Practitioner	Female	Third sector	Non-HCP	Not known

*Healthcare professional

While eight of the 18 participants were based in a university setting at the time of the interview (see Table 4), it is important to clarify the strong practical and applied focus of the work that they were undertaking as part of their involvement with the collaboration. For example, at least two of the core staff of the collaboration were actively involved in supporting local services and teams in implementing new initiatives that could contribute to reducing health inequalities. Likewise, three of the postgraduate research students who took part in the study had themselves just recently entered academia, from different NHS

and local authority settings, for the purposes of undertaking their PhD studies. These participants could be said to be 'straddling' academia and practice, and were thus well positioned to contribute unique insights on how they negotiated the type of research and action that one could and should pursue when tasked with the challenge of working 'upstream' to reduce health inequalities. Additionally, for many of the study participants this negotiating work was further complicated by the expectations and demands of, for example, senior colleagues who had released their time to work with the collaboration or indeed the priorities and interests of supervisory teams. Health inequalities may have been an overarching ambition for the collaboration, but this was not necessarily the case for all individuals and groups who found themselves involved in some way through the collaboration's various funding streams and initiatives.

Being a postgraduate student of the collaboration I was in many ways an "insider researcher" in this study (Corbin Dwyer & Buckle, 2009, p. 55), a status which certainly had its advantages and disadvantages. One advantage was that membership of the collaboration allowed access to participants in the first instance. Additionally, there was a sense of mutual understanding about the complexities of this newly established organisation, and some of the inevitable tensions that had emerged, particularly in relation to the nature of the work being conducted with the aim of reducing health inequalities. Equally however, while I made every effort to assure participants that this study was not an evaluation of the collaboration, nor was it an assessment of how well their work aligned with 'upstream' action to reduce health inequalities, it is likely that due to my 'insider' status participants may have been somewhat cautious in sharing reflections and experiences. Additionally, two of my supervisors formed part of the management team for the collaboration, with one acting as overall director. This information was known to participants and while it was my impression they were candid in sharing their interpretations of the upstream parable and implications for action, it is possible that my position, and that of my supervisors, could have acted to influence how participants framed their responses.

Setting for data collection

The interviews took place at a location of the participants' choosing. These were primarily university offices or classrooms, on-campus cafés, and, in the case of two public advisors, cafés to which they could easily travel. Prior to commencing the interviews, I worked through the information sheet with participants again and asked if they had any questions or points on which they would like clarification. All participants provided written informed consent (Appendix E).

I developed a simple guide for use in the interviews (Appendix F). Each interview opened with a short explanation about what the upstream parable is, and why it is relevant for work around reducing health inequalities. In providing this introduction at the start of the interviews, I endeavoured to give participants sufficient context to understand the rationale for the interview, and what my motivation was for taking this approach within my postgraduate research. However, I was also conscious that having spent a significant amount of time reading and analysing the academic literature on the upstream parable, I was coming into the interviews with a very heavy conceptual lens about its underpinning ideas. To avoid influencing participants with these ideas I aimed to keep these introductions as short and simple as possible, and tended to use lay language, e.g. the upstream parable is asking us to be more ambitious in our efforts to get to the root of the problem, rather than using the language of structural action or population approaches. Due to the somewhat unusual nature of the interviews, where participants were effectively being asked to provide an interpretation of a story that they may or may not have been familiar with, I was conscious that there were likely to be some unique challenges in managing discussions. In an effort to aid discussions, I developed a set of visual prompts reflective of examples that I had identified in the academic account of the literature. In total there were 47 visual prompts organised into five bundles: (1) health risk behaviours, (2) socioeconomic determinants, (3) coverage and effectiveness of NHS interventions, (4) capacity building and public engagement, and (5) activism and advocacy. Examples of these prompts are shown in Appendix G. The visual prompts were intended to support discussions by providing examples of different actions and interventions, while also mitigating against participants' potential concerns that their own work or research was being evaluated in light of the underpinning ideas of the upstream parable. In this way, the prompts were intended to act as a form of vignette to provide participants with alternative scenarios, not as closely related to their own personal experience, around which they could discuss their problematisations of health inequalities and interpretations of the upstream parable. When employing the prompts during the interviews, I presented participants with the five bundles and asked them to pick any bundle which appealed to them. I then asked participants, when flicking through the examples, to share their thoughts about any of the examples and the reasons why they may, or may not, reflect their own ideas about the nature of action being advocated in the upstream parable.

Some participants were very familiar with the upstream parable, and as a consequence had very well-developed perspectives about what it means to work 'upstream'. I tended not to use the prompts in these interviews as they would have worked to disrupt the flow of conversation, and additionally I was concerned that participants might perceive them to be

patronising, or even undermining to their contributions when they had already shared such detailed insights. Additionally, I did not use the prompts for the two participants for whom the upstream parable didn't resonate at all. As these participants felt that they couldn't make sense of the parable, it didn't seem fair to then use the prompts and try to challenge or encourage them to make an assessment about the extent to which different examples could be reflective of 'upstream' actions. In total I used the prompts with seven of the eighteen participants who, while providing an interpretation of the upstream parable, did not have strong opinions on what exactly it referred to, and so benefitted from using the visual prompts to think out loud and articulate how they were distinguishing different types of action in their minds.

The interviews lasted on average forty minutes, with the shortest interview being 31 minutes, and the longest interview lasting one hour. As all participants, with the exception of the public advisors, took part in the interviews during their working hours, I did not offer reimbursement for their time contribution. However, as public advisors are not in salaried roles within the organisation, I provided each advisor with a £20 gift voucher as a token of appreciation for giving up their time. Following the interviews, I immediately transferred the audio-recordings from the two audio-recording devices used to the university secure network. I collected general demographic information on participants which is shown in Table 4, and made short field notes which included my reflections on how I felt the interview had gone, things that worked well, things that hadn't worked so well, any surprises in the interview, or things that challenged my own conceptions about the upstream parable from my analysis of the academic literature.

Transcription and returning of transcripts and summaries to participants

I transcribed the audio-recordings of the interviews as soon as possible after the interview had taken place. Some forms of discourse analysis, which involve close inspection of linguistic components of speech, demand a very detailed level of transcription. However, for the purposes of FDA, where the focus is on how objects and subjects are constituted through the use of macro discourses, a more pragmatic approach to transcription is sufficient (Willig, 2013c, p. 114). By this, I mean that I transcribed the audio-recording near verbatim and included indications of pauses and pertinent non-verbal communication (e.g. laughing, sighs), but did not include details on aspects of speech such as intonation, pitch, volume, etc.

I returned aspects of the raw data and the progressing analysis to my participants on two occasions. First, I returned a single document to each participant which included key extracts from the interview which at this stage I felt may be included in the final write-up.

I opted to do this for two reasons. Firstly, a number of my participants are well-known locally and so I wanted them to feel comfortable that there wouldn't be any raw data included in outputs from the thesis that could comprise their anonymity in the study. Additionally, I wanted to give participants an opportunity to review and revise any of their contributions if they felt that the quotes either didn't fully capture what they felt they had intended to say, or indeed if they had changed their mind on something between the two time-points. At this stage, two participants asked that a single quote be removed from their summaries as they felt that without being able to provide additional context for the point that they were trying to make, it had the potential to be misconstrued. Three participants requested revisions to how the transcripts represented their pauses e.g. requested changes from 'am' to 'uhm'. There were no further requested revisions at this stage. Within this summary document I also inserted comments to give participants an indication as to whether they were the only person to mention a particular point or perspective, or whether the points they had raised were quite prominent across the dataset. As it was likely that the participants would take an interest in the thesis outputs, I was anxious to keep them informed as to how things were progressing and how their ideas were contributing to the dataset and the analysis. The second update to participants involved sharing the two findings chapters in which I present the analysis of the interview data, along with their pseudonym, to allow them to easily search the documents and see their contributions in context. I reflect on some of the potential strengths and limitations of sharing the unfolding analysis with participants in Section 4.5.3.

4.4.Analysis and interpretation

There exist a number of suggested frameworks for conducting a Foucauldian inspired analysis of discourse. These frameworks vary in the emphasis that they place on the different components of a Foucauldian framework, with some approaches privileging the importance of genealogy and historical inquiry (Hook, 2005), some focused on the utility of Foucault's concept of governmentality (Kendall & Wickham, 2004), while others are oriented towards providing step-wise guidance for the analysis of a corpus of texts (Arribas-Ayllon & Walkerdine, 2008; Graham, 2011; Willig, 2013b). What is repeatedly highlighted across all of these texts however, is that a Foucauldian approach to discourse analysis cannot be reduced to a recipe of formal principles, but rather the suggested steps should be understood as "methodological signposts" in undertaking such an analysis (Arribas-Ayllon & Walkerdine, 2008, p. 11).

It was the suggested steps put forward by Willig (2013b) which I found to be most accessible in conducting my first FDA. One omission however from this six-step approach is the tracing of the historical evolution and transformation of the object of study. As such, I have included here an additional step, 'Step 0', which refers to the content presented earlier in Chapter 2, and which I feel plays an important role both in understanding the context for the emergence of the upstream parable, while also providing a conceptual framework for the analysis. I will discuss each of these steps in turn before concluding the section with an overview of how I applied these steps to the two datasets in the study.

Step 0: Tracing history

Arribas-Ayllon and Walkerdine (2008, p. 14) suggest that as long as an FDA is "conducted in terms of recognizing the 'genealogical background' of the study, then any context or setting is suitable for analysis". By this, the authors are suggesting that analysts should first engage with the ways in which discourses have operated over time to construct the object of interest in the study, and power-knowledge relations facilitated through dominant discourses. In Chapter 2, I traced the historical evolution of the object of interest in this study, health inequalities, and endeavoured to illustrate how different discourses, at different points over the last two centuries, have found themselves elevated to the status of truth and have thus been highly influential both in shaping the construction of the problem of health inequalities, and in shaping efforts to address them. In particular, I highlighted the role of neoliberal, behavioural, and evidence-based policy and practice discourses in recent years, which have resulted in a slippage in action away from materialist/structural explanations for health inequalities, to engage in what McKinlay (1979, p. 583) describes as "short-term, problem-specific tinkering". It is in direct response to this slippage that counter-discourses such as the upstream parable emerged in an effort to reorient thinking and action to work at the root causes of health inequalities. Thus, it is against this genealogical background that the present analysis is situated.

Step 1: Look for discursive constructions

Willig (2013b) suggests that the first step of an FDA is to highlight all instances in the text where there is an implicit or explicit reference to the object of interest in the study. Initially, I was unsure as to whether I should be identifying references to 'health inequalities' or working 'upstream' in the texts. However, after trial and error, and after revisiting my research questions, it seemed most sensible to repeat this step for both 'health inequalities' and working 'upstream' to identify the ways in which authors or participants were, through different discourses, constructing each object within the texts. As Graham (2011, p. 668) summarises, the objective of this "foundational starting point' of the analysis is to "trace

the relationship between words and things: how the words we use to conceptualise and communicate end up producing the very 'things' or objects of which we speak".

While Willig (2013b) uses the language of "discursive constructions", I see this expression as synonymous with the idea of problematisations. Thus, in this step in the framework we are looking to go beyond definitions of health inequalities, to see what systems of knowledge and thought people are drawing upon when they are making sense of health inequalities, and offering them up as a particular type of problem to be addressed. In this way, it is possible to identify the ways in which people may employ similar, or indeed stock definitions of health inequalities, but actually produce very different problematisations or discursive constructions within the texts.

Step 2: Look for discourses

In this second step, the task for the researcher is to locate the various problematisations or discursive constructions within wider discourses or "ways of seeing the world" (Willig, 2013b, p. 388). As outlined in Step 1, what can appear as the same discursive object, when situated within wider discourses, can actually be constructed in very different ways. It is these wider discourses that proved particularly useful in bringing to light the ways in which authors and participants had come to understand and look at the problem of health inequalities. Additionally, it is through identifying wider discourses that it then became possible in the analysis to organise authors and participants into groups with distinct ways of seeing the problem.

Step 3-6: Look for the action orientation of discursive constructions

Step 3 of the approach involves looking for the action orientation of discursive constructions within the text. This layer of analysis involves asking of the text, what is gained, or what happens, when people construct health inequalities and working 'upstream' in particular ways? The focus is not so much on the role of the speaker, but rather on the function of discourse, and different discursive constructions. I have presented the final steps together in this section as it is my interpretation that Steps 4-6 of this approach make up the action orientation or the 'effects' of different discursive constructions.

In the first place, Step 4 involves looking for positioning or the different subject positions made available through different discursive constructions. For example, as discussed in Chapter 3, previous qualitative work in this area found that participants tended to construct the problem of health inequalities in terms of a reduced inclination for low income groups to look after their own health, and as a consequence be less receptive to health promotion information and intervention. Thus, this discursive construction situates the drivers of

health inequalities at the level of the individual and positions them in terms of a discourse reminiscent of the 'feckless poor' (see Section 2.1).

Step 5 involves looking for the ways in which different discursive constructions, and the associated subject positions which they produce, operate to "open up or close down opportunities for action" (Willig, 2013b, p. 387). In the example just discussed, depending on the subject positions produced through the discursive constructions, the implications for action could involve reducing spending on health promotion for low income groups as it is seen to be a waste of money, or in contrast, it may be the case that subject positions function to advocate for more intensive intervention in low income areas to compensate for the proposed resistance to change. Importantly, subject positions are not limited to individuals affected by a problem, and indeed it may be the case that particular discursive constructions operate to position some professional groups as best suited, or as having the 'expert' knowledge or skill sets needed to address the problem as it is presented.

And finally, Step 6, while arguably closely related to the idea of subject positions, involves looking for subjectivities that result from particular discursive constructions. Subjectivities refer to the implications of different discursive constructions for how people may think and feel. Willig (2013b, p. 389) provides an illustrative example of this idea of subjectivities, describing how the male sex drive discourse may allow "a man not only to publicly disclaim responsibility for an act of sexual aggression, but to actually *feel* less guilty about it as well" (emphasis in original). These final steps in the analysis are reflective of Foucault's power-knowledge relation, and serve to describe both the productive power of discourses in producing subjects, and the subtle ways in which discourses operate by acting upon the actions of others.

4.4.1.Approach to the analysis

When it came to devising an approach to applying the steps described above to the included texts, I first employed NVivo software for qualitative analysis. Having previously used NVivo in qualitative studies, I expected that it would allow for an efficient approach to keeping track of my coding, along with providing a mechanism for speedy retrieval of passages of text when writing up the analysis. Additionally, for reasons of data safety I was reluctant to produce hard copies of the interview transcripts. However, after multiple efforts, in various ways I had the sense that an analytic approach of this nature did not lend itself quite so well to the rigid structure of codes and nodes afforded by the NVivo software, and as a consequence I quickly reverted to a traditional approach of pen and paper.

I worked through the exact same procedure for the analysis of both the academic texts and the interview transcripts. In line with the framework, I first highlighted all explicit and implicit references to either 'health inequalities' or working 'upstream'. I created two separate Word documents for each dataset, and developed a structure that would allow for the organisation of extracted passages from the texts which were relevant to the six steps of the analytic framework. Prior to populating this Word document, I first applied the six steps to each individual text, making notes both on the printout of the texts themselves, and also supplemental notes in a notepad. I worked through the texts repeatedly until I felt that I had exhausted all of the possible discursive constructions, and resulting action orientations. Using these detailed notes, I produced more compact summaries in the Word document, an example of which is shown in Appendix H. I chose this particular example as it was one of the shortest texts and so allows for the clearest presentation of the analytic approach. The content of these summaries were also developed into summary tables which provided the key findings from each text (example shown at the top of Appendix H). Looking across these summaries, and the resulting tables, I was able to see patterns in discursive constructions and wider discourses, which were then used to inform the structure for presenting the findings. While I made every effort to be consistent and diligent in documenting my analysis, when it came to transforming the analysis of the individual texts into an overall interpretation of the data, I found there was still much work to be done. Thus, a further layer of analysis ensued through the process of developing a structure for presenting the findings in the respective chapters. Beyond applying the analytic steps and producing summaries of the individual texts, the process of drafting and redrafting the findings chapters formed an integral part of developing a 'helicopter view' of both datasets, and in this way further allowed for the identification of patterns, subgroups, agreements, disagreements, and indeed new insights across the entire dataset.

While the theoretical and methodological approaches employed proved to be appropriate to answer the research questions of the thesis, they were not without their limitations. Therefore, in the final section of the chapter I briefly reflect on how I found myself employing a Foucauldian inspired analysis of discourse, and some of the challenges and implications of such an approach.

4.5.Reflections on the approach

I have divided this section of the chapter into three parts. I first reflect on an approach that I had originally employed in the thesis, but which proved to have some fundamental shortcomings which could be addressed using FDA. I then provide some reflections on the

theoretical perspective employed in the thesis, before concluding with some final reflections on the technical aspects of collecting the interview data in particular, and considerations for interpreting the study findings.

4.5.1.Rejecting alternatives

I was quite far into my study, before I came to treat the upstream parable or the idea of working 'upstream' as representative of a counter-discourse in the field of health inequalities. Initially, I was treating 'upstream' as a concept, and so very early I found myself reading extensively around concept analysis, an approach which is most often employed within the nursing literature. The origins of concept analysis can be traced back to a book first written for A level students under the premise 'that a great many adults […] would do better to spend less time in simply accepting the concepts of others uncritically, and more time in learning how to analyse concepts in general' (Wilson, 1970, p. xiii). Within this book, techniques were put forward to assist in examining the internal logic of concepts. These included techniques such as identifying model, contrary, and related cases; examining the social context of use; and the underlying anxieties of the author or speaker in employing a particular concept. These steps have been revised by a number of authors to produce formal approaches to conducting concept analyses (Rodgers, 1989; Walker & Avant, 1988), which are said to have as their primary objective to produce a "precise operational definition that by its very nature increases the validity of the construct; that is, it will accurately reflect its theoretical base" (Walker & Avant, 1988, p. 28). Of most value in employing this approach was the technique of asking: what is the underlying anxiety of the authors in employing the concept in this way? For example, applying this perspective to the academic texts in the first instance helped me to see what is more robustly described in discourse analysis as the action orientation. From the outset however, I had concerns about the appropriateness of looking for a 'precise operational definition' of the concept of 'upstream', and the more I read about concept analysis, the more concerned I became about evident ontological and epistemological tensions. I found the critiques put forward by Bergdahl and Berterö (2016, p. 2560) particularly compelling where they outlined that the underlying assumption that there can exist a 'proper' definition of a concept is an idea which is completely at odds with findings from the philosophy of language. However, time spent engaged with this approach was not time wasted. I returned to the methodological literature to seek out a more robust alternative and, as a consequence of the new insights gained through this exercise, I was now able to see the fit between my research questions and the work of Michel Foucault and discourse analysis.

4.5.2.Reflections on the theoretical perspective

One challenging aspect of employing a Foucauldian approach to the study was coming to understand the implications for the extent to which I could, or indeed should, engage in some form of critique in my analysis and make normative assessments about how things are, and as a consequence claims about how things ought to be. Health inequalities are a value-laden issue which, employing here a traditional notion of power, involve profound imbalances in both power and resources. As a consequence, it would seem self-evident that a study on health inequalities would involve some form of critique of these power imbalances and thus aim to bring to light dominant ideologies which serve to sustain the status quo. However, as discussed in Chapter 1, Foucault rejects the idea of ideology and is notorious for the lack of solutions proposed in his work. A Foucauldian approach is therefore better understood in terms of producing diagnoses of the present, through employing an analysis of problems of the past. Foucault himself nicely summarises his outlook when he said:

> I am not looking for an alternative; you can't find the solution of a problem in the solution of another problem raised at another moment by other people. You see, what I want to do is not the history of solutions, and that's why I don't accept the word *alternative*. I would like to do genealogy of problems, or *problématiques*. (emphasis in original)
>
> (Foucault, 1984a, p. 343)

Gee (2010, p. 9) succinctly captures the distinction, and indeed the tensions, between more descriptive and critical approaches to discourse analysis. He suggests that often people who take a descriptive approach consider a critical approach to be "unscientific" as a consequence of a perceived undue influence of the researcher's own political interest on the analysis and findings of a study. Likewise, people who take a critical approach would consider a descriptive approach to be an evasion of moral responsibility in light of what are such profound social injustices. However, Gee (2010) puts forward an appealing middle ground which suggests that all discourse analyses are unavoidably critical, not in the sense that they are overtly partisan or political, but because they involve the analyses of what Foucault would describe as 'regimes of truth', which will *always* have effects for the distribution of social goods and resources. Thus, in this thesis I see the approach taken as critical in the sense that it aims to bring to light 'regimes of truth' which operate to shape dominant constructions of the problem of health inequalities, thus having important implications for the nature of action pursued to reduce health inequalities.

It is my reflection that taking this approach has been particularly useful in this study. Having immersed myself in the health inequalities literature, I very quickly became

preoccupied with particular aspects of the 'upstream' literature. In particular, I became quite fixated on particular types of policies and interventions which appeared in the typologies distinguishing 'upstream' from 'downstream' action. This perspective was then reflected in my early interviews, where I found myself somewhat uninspired by what I was hearing when it didn't neatly map onto the concepts that I had in my mind. I found myself thinking that some of my participants just didn't really get it, they didn't understand big picture health inequalities, and they couldn't look beyond their own bubble of action to aspire to something a bit more radical. This experience is perhaps reflective of the frustrations evidently experienced by authors of the empirical studies synthesised in Chapter 3. However, with the input of my supervisory team I was encouraged to bracket as far as possible some of the ideas which I had gleaned from the academic literature. As a result, I feel I relaxed my approach in my interviews and started to listen a lot more carefully to what people were saying, how they were saying it, what ideas were influential, and what was achieved by the different framings and problematisations that they employed. As a consequence of this approach, I feel that I have been able to provide a much more authentic account of the sense-making work that people do, as opposed to superimposing upon the data preconceived ideas about the 'right' interpretation of the upstream parable. It has therefore been my experience that an approach underpinned by Foucault and poststructuralist ideas, which apply the same scepticism towards all taken-for-granted truths, has resulted in a more thorough and robust analysis of what is undeniably an area fraught with ideological leanings.

4.5.3.Reflections on the methodology

In this final section, I briefly reflect on three aspects of the methodological approach which I feel either need some additional justification, or should be taken into consideration when interpreting the study findings. These include (1) the decision to focus only on academic texts, (2) regularly sharing the progress of my analysis with study participants, and (3) data extracting and applying the analytic framework in isolation (i.e. not having a second person independently extract/code the texts). I will discuss each in turn.

The rationale for focusing solely on academic texts, at the expense of including government policy or reports from non-governmental organisations was two-fold. Firstly, I hypothesised that the recommendations put forward in relation to working 'upstream' within these reports would themselves be underpinned by academic texts. However, more importantly, and reflective of the challenge of conducting interviews to produce data for discourse analyses from the perspective of discursive psychology, it was my impression that conducting a Foucauldian discourse analysis of such reports would be asking and

answering a different question to the one I had in mind. By this I mean that such an approach would have answered a question about how the upstream counter discourse is *managed* within such policy documents, which must, invariably, be more diplomatic in their articulations of proposals for action. Thus, to fully grasp what was *originally* intended with the introduction of the upstream parable, I felt that it was sensible to work with academic texts alone in the first instance. Additionally, a thesis has been recently conducted which applied a poststructural perspective to key health inequalities policies to examine how the problem of health inequalities is constructed within these texts (Kriznik, 2015). The author employed Carol Bacchi's model which provides a step-wise approach in examining 'What's the Problem Represented to be?' (Bacchi, 2012).

The decision to focus on the academic literature alone was also a pragmatic one. As described in the Introduction to the thesis, I did not set out to conduct a discourse analysis of the upstream parable. As such, when first collating and familiarising myself with the literature employing the upstream parable to articulate new ways of working, I hadn't realised the potential for an analysis of these texts to form a findings chapter of the thesis. As a consequence, the approach to searching, selecting, and analysing these texts was iterative and evolving, culminating in the eventual use of a Foucauldian framework and discourse analysis. Once I had retrieved what I felt to be a robust sample of academic texts which could contribute to the study aims I opted not to include or continue to search for texts in the grey literature. Thus, it is important to bear in mind that there is undoubtedly a wealth of other sources (e.g. books), and in particular seminal health inequalities reports, which could also have contributed to this discourse analysis. Despite this limitation however, it is my assertion that while some of the included texts may appear to sit on the periphery of the health inequalities literature, they have each made a useful contribution to building up a picture of the different ways in which people employ the language of 'upstream' or the upstream parable to encourage new ways of working. As such, while limited by the underpinning texts, the output of the discourse analysis presented in Chapter 5 provides a useful starting point for unpacking what I have described as the upstream 'counter-discourse', which could, in the future, be further tested and refined by introducing different texts and perspectives into the analytic frame.

My second reflection relates to the sharing of the progress of my analysis with study participants. In discourse analytic studies, it is not typical to engage in this form of validation exercise, for a number of reasons. One reason put forward by Hammersley (2014, p. 533) is that outputs of discourse analytic studies can end up being completely incomprehensible to study participants. Indeed, Hammersley (2014) also suggests that

when studies are framed as an analysis of the function of language for example, it can be difficult for participants to see the value of such work, or to view it as worthwhile. However, as highlighted in Section 4.3.2, in this study I found myself as an 'insider researcher', and so I felt a certain responsibility to be as transparent as possible with my participants whom I had the opportunity to speak to through my membership of the research collaboration. Additionally, I was conscious that, as the objectives of the study were so closely related to the day-to-day experiences of participants working to reduce health inequalities, they would take an active interest in the outputs of the work. Indeed, I felt very fortunate that many of my participants explicitly outlined their interest in seeing the study outputs and thus getting a sense of how their ideas fit with those of other members of the collaboration. While I feel that sharing the progress of my analysis is a strength of the study and ensured that I was constantly reflecting on the accuracy and appropriateness of my analysis, it is possible that such close involvement of my participants may have caused me to be wary of presenting them in a negative light. I think this point closely relates to that of avoiding an overtly critical stance described above, whereby orienting my analysis towards providing a detailed descriptive account of the sense-making work in which participants engaged, allowed me to avoid making normative assessments as to the extent to which participants held 'right' or 'wrong' insights, or indeed the extent to which participants were beholden to a dominant ideology, an approach common in similar studies (see Chapter 3).

The last point that merits attention relates to the procedure for conducting the analysis itself. Due to the iterative nature of the work, and the continuous refining of the research questions and approach to the analysis, it was not feasible in this study to have a second person independently check my data extractions and the application of the analytic framework. For discourse analysis studies however, it has been suggested that one of the reasons for avoiding a strict systematic approach for conducting the analysis is that "no matter how standardised the process, the analysis of language by different people will seldom yield the same result" (Graham, 2011, p. 666). Similarly, it is accepted with this methodology that the analysis produced will never be "the only possible reading" of the included texts (Cheek, 2004, p. 1147). As such, the lack of dual selection and data extraction should not be viewed as a limitation of the analysis, but rather the analysis should be viewed as one of many potential readings and interpretations of the data.

4.6.Chapter summary

The aim of this chapter has been to detail the methodological approach to the study. To answer the research questions of the thesis, I constructed two datasets to which I applied

the six steps of Foucauldian discourse analysis. Chapters 5, 6, and 7 are dedicated to presenting the findings of the analyses. In Chapter 5, I present an academic account of the upstream counter-discourse based on my analysis of 32 peer-reviewed articles. Chapter 6 focuses on presenting participants' interpretations of the upstream parable, while Chapter 7 provides an account of changes that participants perceived as needing to happen in order to actualise the interpretations set out in Chapter 6. All chapters are underpinned by the six-step framework and thus aim to describe how discourses operate to construct problems in particular ways, along with demonstrating the action orientation of different discourses. However, each of the three chapters follows a slightly different structure to allow for the most coherent and clear presentation of the main findings in light of the research questions.

CHAPTER 5: AN ACADEMIC ACCOUNT OF THE COUNTER-DISCOURSE

As outlined at the close of Chapter 4, this first findings chapter presents an academic account of the upstream counter-discourse, based on a Foucauldian discourse analysis of 32 peer-reviewed articles. I open the chapter with a detailed summary of the included articles, before outlining what I have identified as three threads to the counter-discourse. These threads each represent a different problem to which the upstream counter-discourse is a response. In contrast to the typical use of the upstream parable, these threads go beyond recommending specific policies and interventions, to also addressing the dominant mode of knowledge production, and the process work needed to bring about the implementation of more ambitious action at the root causes of health inequalities. The main body of the chapter takes each of these three threads in turn, and each section follows the same format. I first summarise the rationale for the respective proposals, which reflect authors' constructions of the problem of health inequalities and the idea of working 'upstream'. I then discuss the effects of each proposal in terms of their action orientation, the subject positions which they create, and the opportunities for action which they operate to open up, or indeed close down. I conclude the chapter by highlighting some ambiguous uses of the language of the upstream parable identified in the literature, before providing a summary of the key findings of the analysis.

5.1.Introducing the texts

An overview of the academic texts included in the data extraction and analysis is provided in Table 5. The texts are ordered alphabetically, and for each I have provided a short synopsis. The final column in the table details the section in this chapter to which the text made the most significant contribution. Importantly, a number of texts, while equating 'upstream' with particular types of policies and interventions, actually contributed to the analysis primarily in terms of what needed to happen to assure the implementation of such actions. As can be seen in Table 5, in these instances I have detailed in brackets the nature of policies or interventions advocated within these texts. Equally however, there were texts which didn't explicitly equate 'upstream' with specific types of policies or programmes, but rather employed the language of the upstream parable to describe a range of actions reflective of a particular way of looking at the problem. In these instances, I have noted this in brackets in the final column.

Table 5. Academic texts included in the analysis

No.	Citation	Country	Title	Synopsis	Main contribution
1	Alberga, Russell-Mayhew, von Ranson, and McLaren (2016)	Canada	Weight bias: a call to action	Discussion article making the case for weight bias and stigma as a fundamental cause of health inequalities. Calls for an 'upstream' population-level approach to tackle weight bias which would include intervention strategies higher up on the intervention ladder.	Section 5.3.1: Intervention ladder
2	Amaro (2014)	USA	The Action Is Upstream: Place-Based Approaches for Achieving Population Health and Health Equity	Editor's commentary providing a critique of individual-level interventions and a call to action for the public health profession to revisit the role of community organising and academic-community partnerships for population health.	Section 5.5.2: Transformative action (multiple)
3	Asthana and Halliday (2006)	UK	Developing an Evidence Base for Policies and Interventions to Address Health Inequalities: The Analysis of "Public Health Regimes"	Discussion article which examines the limitations of systematic review methodology for synthesising evidence policies to reduce health inequalities. Proposes the use of the 'public health regime' as an analytic framework to capture the socio-political context which shapes the implementation of 'upstream' policies targeting the wider determinants.	Section 5.4.1: Methodological pluralism (reduce socioeconomic inequality)
4	Baelum (2011)	Denmark	Dentistry and population approaches for preventing dental diseases	Discussion article which critiques prevention efforts of the dentistry profession which are limited to chairside advice and information. Call for 'upstream' structural healthy policy to support universal and equitable improvements in oral health.	Section 5.3.1: Intervention ladder
5	Bambra et al. (2010)	UK	Reducing health inequalities in priority public health conditions: using rapid review to develop proposals for evidence-based policy	Methodological paper outlining the review methods employed by the *Marmot Review* priority public health conditions task group. Suggests that the evidence base is not conclusive on whether 'upstream', 'downstream', 'targeted' or 'universal' approaches are most effective.	Section 5.3.1: Intervention ladder
6	Butterfield (2017)	USA	Thinking Upstream A 25-Year Retrospective and Conceptual Model Aimed at Reducing Health Inequities	Discussion article which provides a synthesis of the concept of thinking 'upstream' in the context of public health nursing. The author presents a new model: the Butterfield Upstream Model for Population Health (BUMP Health) which is underpinned by theories of system change.	Section 5.5.3: Systems change (multiple)

No.	Citation	Country	Title	Synopsis	Main contribution
7	Capewell and Kypridemos (2017)	UK	Socioeconomic Inequalities in Dietary Sodium Intake: Upstream Versus Downstream Interventions	Discussion article describing the findings of a systematic review which found that 'upstream' strategies involving multicomponent population-wide policies result in the largest reductions in sodium intake. Authors call for greater attention to be paid to the 'effectiveness hierarchy'.	Section 5.3.1: Intervention ladder
8	Carey and Crammond (2015)	Australia	Systems change for the social determinants of health	Analysis of the recommendations from major social determinants of health reports using two frameworks on 'system leverage points'. Authors suggest that to achieve 'upstream' change (described as change within government policy) a better understanding is needed of how interventions work to bring about change within systems.	Section 5.5.3: Systems change (reduce socioeconomic inequality)
9	Drake and Gahagan (2015)	Canada	Working "Upstream": Why We Shouldn't Use Heterosexual Women as Health Promotion Change Agents in HIV-Prevention Interventions Aimed at Heterosexual Men	Reflective critique on what are perceived to be increasingly problematic models of health promotion that fail to address the role of gender inequality in the HIV transmission while simultaneously reinforcing potentially harmful gender norms.	Section 5.3.3: Social norms
10	Falk-Rafael and Betker (2012)	Canada	Witnessing Social Injustice Downstream and Advocating for Health Equity Upstream "The Trombone Slide" of Nursing	Qualitative study with experienced community health nurses to explore the application of a midrange nursing theory grounded in critical theory and social activism. Moving 'upstream' equated with political advocacy and advocating for healthy public policy.	Section 5.5.1: Political literacy & advocacy (not specified)
11	Freudenberg, Franzosa, Chisholm, and Libman (2015)	USA	New Approaches for Moving Upstream: How State and Local Health Departments Can Transform Practice to Reduce Health Inequalities	Article profiling three campaigns in the United States that illustrate how health educators working in health departments can reorient their practice and engage in transformative action that works to reallocate the wealth and power that shapes living conditions and health inequalities.	Section 5.5.2: Transformative action (reduce socioeconomic inequality)

No.	Citation	Country	Title	Synopsis	Main contribution
12	Gilbert (2012)	South Africa	'Upstream/downstream' – locating the 'social' in health promotion and HIV/AIDS in South Africa?	Discussion article critiquing of the lack of fit between the forces shaping the HIV/AIDS epidemic and efforts to prevent its spread. Employs the upstream metaphor and the associated typology from McKinlay (2000). Calls for a more comprehensive approach with a greater focus on the 'social'.	Section 5.3.3: Social norms
13	Kaplan (2002)	USA	Upstream approaches to reducing socioeconomic inequalities in health	Discussion article describing socioeconomic inequalities in health and presenting a multilevel model of disease causation. Attention is drawn to 'upstream' redistributive approaches that can work to address income inequality.	Section 5.3.2: Reduce socioeconomic inequality
14	Koyio, Ranganathan, Kattappagari, Williams, and Robinson (2016)	India	Oral health needs assessment world-wide in relation to HIV. Themes: Oral health needs and inequalities, oral health promotion, co-ordinating research and enhancing dissemination in relation to HIV- a workshop report	Report on a workshop considering oral health promotion and oral health inequalities among people with HIV. The framework from Watt (2007) was used to distinguish 'upstream' healthy public policy from downstream individual lifestyle approaches and called for stronger leadership and advocacy to reduce oral health inequalities for people with HIV infection.	Section 5.5.1: Political literacy & advocacy (intervention ladder)
15	Lorenc, Petticrew, Welch, and Tugwell (2013)	UK	What types of interventions generate inequalities? Evidence from systematic reviews	An overview of systematic reviews which examined which types of interventions could act to generate or increase health inequalities. 'Upstream' structural environmental change was suggested to decrease inequalities, and downstream interventions focused on individual factors were suggested to increase inequalities.	Section 5.3.1: Intervention ladder
16	Mabhala (2015)	UK	Public health nurse educators' conceptualisation of public health as a strategy to reduce health inequalities: a qualitative study	Qualitative study which employs a social justice perspective to examine participants' understanding of the relationship between public health and action to reduce health inequalities. The language of 'upstream' is used interchangeably to describe preventative interventions and population approaches.	Section 5.6: Inconsistent use of 'upstream'

No.	Citation	Country	Title	Synopsis	Main contribution
17	McGill et al. (2015)	UK	Are interventions to promote healthy eating equally effective for all? Systematic review of socioeconomic inequalities in impact	Systematic review to examine the equity effects of healthy eating interventions. A marketing model with six intervention categories was used to distinguish 'upstream' from 'downstream' interventions. The review found 'upstream' interventions, such as those categorised as price interventions to be more likely to reduce dietary inequalities.	Section 5.3.1: Intervention ladder
18	McKinlay and Marceau (2000)	USA	To Boldly Go . . .	Discussion article highlighting the limited ability of the dominant public health paradigm to tackle the complex problems of the new millennium. A call to researchers to develop a greater insight into the philosophical and theoretical underpinnings of public health practice and appreciate their role in socio-political action to shape healthy public policy.	Section 5.5.1: Political literacy & advocacy (intervention ladder)
19	Ndumbe-Eyoh and Moffatt (2013)	Canada	Intersectoral action for health equity: a rapid systematic review	Systematic review on the effectiveness of intersectoral action on health equity through action on the social determinants of health. Interventions categorised as 'upstream' if they include reform of fundamental social and economic structures and involve mechanisms for the redistribution of wealth.	Section 5.3.2: Reduce socioeconomic inequality
20	O'Flaherty, Buchan, and Capewell (2013)	UK	Contributions of treatment and lifestyle to declining CVD mortality: why have CVD mortality rates declined so much since the 1960s?	Discussion article outlining the effectiveness of public health approaches focused on 'upstream' population-wide policies and the challenge of generating political support for such policies.	Section 5.3.1: Intervention ladder
21	Orton et al. (2011)	UK	Prioritising public health: a qualitative study of decision making to reduce health inequalities	A qualitative study with decision-makers working in cardiovascular disease to explore experiences of working to reduce health inequalities. 'Upstream' approaches considered in terms of primary prevention initiatives.	Section 5.6: Inconsistent use of 'upstream'
22	Pearce (1996)	New Zealand	Traditional Epidemiology, Modern Epidemiology, and Public Health	Discussion article providing a critique of modern epidemiology and calling for the renewal of a population perspective in epidemiology.	Section 5.4.1: Methodological pluralism (intervention ladder)

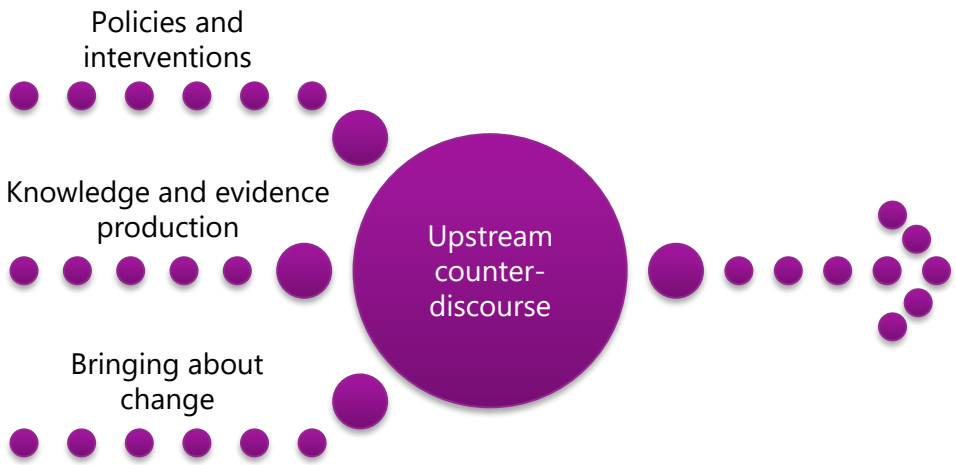
No.	Citation	Country	Title	Synopsis	Main contribution
23	Smith and Kandlik Eltanani (2015)	UK	What kinds of policies to reduce health inequalities in the UK do researchers support?	Findings of an online survey to examine if there was consensus among researchers about the nature of policies that would be most likely to reduce health inequalities. Support for various policies differed if participants were asked about their opinion or the strength of the available evidence. 'Upstream' polices described as redistributive socioeconomic policies.	Section 5.4.1: Methodological pluralism (reduce socioeconomic inequality)
24	SmithBattle (2012)	USA	Moving Policies Upstream to Mitigate the Social Determinants of Early Childbearing	Discussion article which provides a detailed critique of the role of state policy in shaping public perception of teenage and single mothers and calls upon the profession of public health nursing to challenge ideological assumptions that are driving 'downstream' policies for early childbearing and reorient action towards 'upstream' redistributive policies.	Section 5.3.2: Reduce socioeconomic inequality
25	Storey-Kuyl, Bekemeier, and Conley (2015)	USA	Focusing ''upstream'' to Address Maternal and Child Health Inequities: Two Local Health Departments in Washington State Make the Transition	Article describing the process through which the Maternal and Child Health services within local health departments reoriented their practice from an individual-focused home visiting model to population-focused, place-based models.	Section 5.5.2: Transformative action (multiple)
26	Thomson, Bambra, McNamara, Huijts, and Todd (2016)	UK	The effects of public health policies on population health and health inequalities in European welfare states: protocol for an umbrella review	Protocol for an umbrella review to examine the effects of 'upstream', population-level public health policies on health and health inequalities.	Section 5.3.1: Intervention ladder
27	Vandevijvere, Swinburn, and for INFORMAS (2014)	New Zealand	Towards global benchmarking of food environments and policies to reduce obesity and diet-related non-communicable diseases: design and methods for nation-wide surveys	Protocol for a national survey on the healthiness of food environments; equity indicators; and the public and private sector policies influencing them. Described as an 'upstream' approach due to the focus on the interface of where policies meet environments, and the use of 'upstream' indicators.	Section 5.3.1: Intervention ladder

No.	Citation	Country	Title	Synopsis	Main contribution
28	Wallack and Thornburg (2016)	USA	Developmental Origins, Epigenetics, and Equity: Moving Upstream	Discussion article on the role of epigenetics in redefining the meaning of what it means to move 'upstream' by refocusing attention on the most fundamental drivers of inequity. Call for a social movement that can generate political will needed to implement policies that can assure conditions for health.	Section 5.5.1: Political literacy & advocacy (reduce socioeconomic inequality)
29	Waters et al. (2008)	Australia	Evidence synthesis, upstream determinants and health inequalities: the role of a proposed new Cochrane Public Health Review Group	Commentary on the role of the Cochrane Public Health Review Group in synthesising the equity effects of 'upstream' interventions to address material and social structural conditions. Authors highlight the need to include multiple forms of evidence in the public health evidence base.	Section 5.4.1: Methodological pluralism (reduce socioeconomic inequality)
30	Watt (2007)	UK	From victim blaming to upstream action: tackling the social determinants of oral health inequalities	Discussion article critiquing preventative efforts from the dentists are guided by a narrow focus on changing the behaviours of high-risk individuals. Puts forward an upstream-downstream continuum of intervention where 'upstream' is equated with healthy public policy.	Section 5.3.1: Intervention ladder
31	Whitehead and Popay (2010)	UK	Swimming upstream? Taking action on the social determinants of health inequalities	Part of Social Science & Medicine series reflecting on the *Marmot Review*. Positive critique of the report, while also highlighting a lack of detail on how to tackle what are described as the countervailing forces driving income inequality to bring about 'upstream' social reform.	Section 5.3.2: Reduce socioeconomic inequality
32	Willen, Knipper, Abadía-Barrero, and Davidovitch (2017)	USA	Syndemic vulnerability and the right to health	Discussion article outlining the role for a combined approach of syndemics (the study of synergistic interactions between comorbid conditions, especially during political adversity) and human rights in providing tools and insights needed to engage in 'upstream' intervention at the level of the social, political, and structural determinants.	Section 5.5.1: Political literacy & advocacy (reduce socioeconomic inequality)

5.2.Three threads of the counter-discourse

In applying the steps of Foucauldian discourse analysis to the included academic texts, I identified three 'threads' that tie together to form the upstream counter-discourse (Figure 3). Each of the threads represents a different problem to which the counter-discourse is a response. The first problem is the types of policies and interventions that we implement in our efforts to reduce health inequalities. The second problem is the dominant approach to knowledge and evidence production, which has implications for the types of policies and interventions that are implemented. The third problem is the process through which we generate support for, and implement, the actions proposed within the counter-discourse. I will present the findings for each of these problems in turn and illustrate the different proposals put forward through the counter-discourse in response to each.

Figure 3. Three threads of the upstream counter-discourse



5.3.Problem 1: Influence of behaviour change theory

In recounting the evolution and transformation of the problem of health inequalities in Chapter 2, I highlighted the emergence of the upstream parable in 1979 in direct response to the influence of individualism and neoliberalism in shaping how we look at and understand the problem. It was therefore not surprising to find that the primary anxiety of authors across the dataset was the influence of theories of individual behaviour change in shaping action to reduce health inequalities. As demonstrated by the quotes in Table 6, authors described action underpinned by models of behaviour change as 'downstream' in nature, and critiqued the manner in which these approaches positioned individuals as both failing to assume responsibility for their

health, and failing to make rational choices to maintain their health. In light of these theories, the cause of the problem is situated within individuals, and as a consequence solutions are framed in terms of efforts to prompt or nudge individuals to make better choices to maximise their health.

Table 6. Critiques of models of individual behaviour change

Citation	Exemplar quotes
Baelum (2011)	Most interventions aiming at changing people's oral health related behaviours are founded in theoretical behavioural models which are based on psychological theories seeking to explain individuals' behaviour as a function of their beliefs and attitudes or their self-efficacy. Whilst some acknowledge the influence of material wealth, social norms, and social support and community expectations on individual health-related behaviours, interventions based on these models have remained focused on empowering individuals to personally assume responsibility for their own health. This approach is insufficient and a key reason why such interventions may increase social disparities in health. (p.S12)
Drake and Gahagan (2015)	While cognitive–behavioral interventions may increase women's awareness of the choices they could potentially make to improve their short- and long-term health outcomes, they cannot permeate the gender-based social, legal, or political conditions that conspire to further spread HIV. In other words, there are many micro and macro determinants of health that impede the implementation of positive behavior change, and given rigid social structures, many women may not have a "choice" to make when it comes to their sexual and reproductive health and autonomy. (p.1276)
SmithBattle (2012)	A downstream approach is driven by epistemological and political assumptions that strip the person from the meanings and contexts that ground experience in a given life-world. This stripped-down person exists in a vacuum, disconnected from local settings and the larger socio-economic structures that organize and constrain individual actions, forms of life, and ways of being (e.g., a teen, a mother). (p.449)

The concern for many authors was that action underpinned by such perspectives were doomed to fail, and actually in many instances posed the risk of compounding the issue and widening health inequalities. In employing the language of 'upstream' and the upstream parable, authors put forward three relatively distinct proposals for action. The proposals include implementing: (1) interventions higher up on the intervention ladder, (2) policies to reduce socioeconomic inequality, and (3) interventions that could change social norms.

5.3.1. Proposal 1: Implement actions higher up on the intervention ladder

Across the dataset, interventions most frequently described as 'upstream' were those that place higher on the intervention ladder. The intervention ladder was designed by the Nuffield Council on Bioethics to illustrate the spectrum of public health intervention options (Nuffield Council on Bioethics, 2007). Working at the lowest rung on the ladder is to 'do nothing', moving through 'provide information', 'enable choice', 'guide choice by changing the default policy', 'guide choice by incentives', 'guide choice by disincentives', up to the highest rungs on the ladder of 'restrict choice' and 'eliminate choice'. Exemplar quotes demonstrating the call for more restrictive policy action to reduce health inequalities are shown in Table 7. For transparency it is important to note that only one of the included texts made explicit reference to the "intervention ladder" (Alberga et al., 2016, p. 3), with the remainder using expressions such as 'effectiveness hierarchy' or 'population approaches'.

Rationale for the proposal

Within the Nuffield Council report it was suggested that where possible, action lower down on the intervention ladder is preferable, and should action higher on the ladder be implemented, there would need to be very strong justification for both the seriousness of the suggested risk and the potential benefits of highly restrictive action (Nuffield Council on Bioethics, 2007, p. 42). However, due to increasing concern over widening health inequalities, and, in particular, the potential for actions lower down the ladder to inadvertently increase health inequalities, the upstream counter-discourse is now regularly employed to propose more restrictive policy action.

McGill et al. (2015) for example, describe the potential for differential outcomes to arise from healthy eating interventions which are positioned lower down on the intervention ladder, due to "compliance" with such interventions being "higher among more advantaged groups because of better access to resources such as time, finance, and coping skills" (p.2). This explanation is much the same as Capewell and Kypridemos (2017), who conclude that for "deprived individuals, energy-dense junk food is generally cheaper, more available, and more convenient than healthier options" (p.500), and as such their "compliance with dietary guidelines" would not meet the same levels as their more affluent counterparts. Baelum (2011) goes further in providing a rationale for more restrictive action, suggesting that the experience of "poor people living in poor places" results in "serious impediments to self-care" as a consequence of "undermined social capital and social exclusion and an ensuing

reduction of hopes, self esteem and perceptions of control, and increased fatalism and pessimism" (p.S12). Within this proposal, people from lower socioeconomic groups are positioned as lacking in the required resources needed to resist the unhealthy environments to which they are exposed, thus legitimating the call for more restrictive action which targets environments over individuals.

Table 7. Proposals for action higher up the intervention ladder

Citation	Exemplar quotes
Baelum (2011)	Innovators and early adopters tend to have the necessary economic and social resources for readily changing, whilst late adopters, who often belong to less resourceful social strata, perceive more barriers to change. Thereby, it is sensible to distinguish between population strategies, in which individual behaviour is directly targeted (e.g., through health education and behavioural campaigns), and structural strategies, in which individuals [sic] behaviours are indirectly targeted through regulation of the conditions and circumstances leading to unhealthy behaviours (e.g., ban on smoking in public places) or taxation (e.g., tax on cigarettes or VAT exemptions for fruit and vegetables). (S13)
McGill et al. (2015)	White et al. suggest that how an intervention is delivered is crucial. Hence structural, universally delivered "upstream" interventions which create a healthier environment therefore tend to circumvent voluntary behaviour change may well reduce inequalities. (p.15)
Capewell and Kypridemos (2017)	Upstream policy interventions designed to reduce sodium intake (or tobacco use, alcohol use, or exposure to other environmental hazards) may thus be more powerful, more equitable, and more cost-effective (or even cost-saving) than downstream interventions. Yet, regulation and taxation are also more politically difficult and may be criticized as promoting a "nanny state"; however, the nanny state, rather than being interfering and intrusive, is in fact a powerful factor for good. (p.500)

An additional rationale for more restrictive action is that as the burden of both risk and disease is higher in groups of lower socioeconomic position, it is these groups who have the most to gain by a uniform reduction in risk exposure across the entire population. A recent umbrella review by Lorenc et al. (2013) went some way towards testing the theory that 'downstream' interventions could generate what they term "intervention generated inequalities" (IGIs). The authors tentatively concluded that 'upstream' interventions, defined in the review as those "focusing on social or policy-level determinants such as reducing price barriers" (p.191), were more likely to reduce health inequalities, while downstream interventions were more likely to increase them. Despite the explicit caveat in the text that "in no case is the evidence

conclusive" (p.191) and that "our conclusion that downstream interventions are more likely to produce IGIs should be regarded as tentative and provisional" (p.192), it remains a heavily cited review, often employed to support proposals for the equity effects of more restrictive policy action.

In articulating their proposals for action, most authors drew primarily upon the work of Geoffrey Rose and his population approach (Rose, G., 2001). The population approach has its roots in traditional epidemiology and suggests that "a large number of people exposed to a small risk may generate many more cases than a small number exposed to a high risk" (Baelum, 2011, p. S11). Baelum's call to action for the profession of dentistry is to move beyond chairside prevention with the high risk tail of the caries curve and engage in more equitable population approaches to oral disease prevention. The author also draws on the influential article from McLaren, McIntyre, and Kirkpatrick (2010, p. 374) who put forward a revised conceptualisation of the population approach reflective of the thinking behind the intervention ladder. They suggest that a 'population approach' can be further divided into action that is either 'structural' or 'agentic' in nature. 'Structural' action seeks to make changes to the physical environment, whereas 'agentic' policies aim to bring about a change in individual behaviour. McGill et al. (2015) describe these structural policies as those which "tend to circumvent voluntary behaviour change" (p.9), while Capewell and Kypridemos (2017) use the expression of the "effectiveness hierarchy" (p.499) to refer to such regulatory policies. Although not explicitly situating their work within a population approach, the text by Vandevijvere et al. (2014) similarly aims to examine 'upstream' policy level action which shapes the food landscape.

Effects of the proposal

While the nature of 'upstream' action advocated within this proposal is clear, across the texts authors consistently made reference to the extent to which such actions were palatable for professionals themselves, along with government and indeed the public. For example, O'Flaherty et al. (2013) in discussing more restrictive interventions to reduce inequalities in cardiovascular disease highlight the preference of politicians to "emphasise individual responsibility, or rely on less contentious but weak voluntary agreements with the food industry" (p.160). In this critical account the authors outline that "the food industry aims to make money, not promote public health" and that in order to shape future policy decisions "a more critical societal engagement with the food industry" on the part of the public is also required (p.161). Similarly, Koyio et al. (2016), describe such 'upstream' approaches as appearing

"more radical" (p.201), while Baelum (2011) remarks that in order to revise the current system in line with the ideal, what is needed is "a tremendous commitment and political will on the part of the public and their elected officials" (p.S16). Thus, the effects of the population approach discourse are to reintroduce business and commercial interests back into the frame and position them as generating profits from products which are detrimental to population health. Politicians, and to some extent the public, are positioned as unwilling to more critically engage with industry to both hold them to account, and call for increased market regulation to reduce negative impacts of industry.

It is important to note however that some authors expressed concern over uncritical support for restrictive policy action. For example, Pearce (1996), although advocating for a population approach, suggests that there is always the "danger of a social engineering approach to public health itself", which should be avoided, and rather actions should be pursued which work to "increase rather than decrease individuals' control over their environment" (p.681). Additionally, Bambra et al. (2010), in their methodological account of their rapid review on strategies to reduce inequalities in priority public health conditions, demonstrated a certain wariness in making broad conclusions about the equity effects of 'upstream' versus 'downstream' intervention strategies. In particular, they draw attention to the use of fiscal disincentives such as minimum unit pricing of alcohol or tobacco taxes and suggest that such policies could be seen both as "strongly regressive" (p.501) and actually as "disempowering" (p.503) due to the potential further imbalances in power and resources likely to be experienced by low income groups.

Summary

An overview of the components of the intervention ladder proposal is presented in Figure 4. Authors employing a population approach discourse, and thus proposing action higher up on the intervention ladder, consistently constructed the problem of health inequalities in terms of the inequitable distribution of unhealthy environments, and also in terms of the potential differential effects of public health interventions and policies across social groups. In almost all cases authors were thinking about specific instances of inequalities e.g. inequalities in oral disease (Baelum, 2011; Koyio et al., 2016; Watt, 2007), and inequalities in diet (Capewell & Kypridemos, 2017; McGill et al., 2015; O'Flaherty et al., 2013). This perspective positions low income groups as lacking the capacity to resist the negative outputs of the free market, while also shifting responsibility to politicians to take action on

industry. The single exception to the dominant construction of health inequalities was the text by Alberga et al. (2016). The authors here employed the language of social inequity to draw attention to the role of stigma and weight bias in contributing to health inequalities in the social group of "larger bodies" (p.3). In this text the authors explicitly call for action higher up on the intervention ladder (e.g. "develop legislation to prohibit weight discrimination" (p.4)).

Figure 4. Components of the intervention ladder proposal

5.3.2. Proposal 2: Implement policies that reduce socioeconomic inequality

The second proposal identified within the dataset was that of implementing policies to reduce socioeconomic inequality. Authors called for the implementation of redistributive policies which involve the transfer of income and wealth from some individuals and groups in society to others, through mechanisms such as taxation, public services, and welfare. Exemplar quotes that illustrate authors' calls for such policies are shown in Table 8.

Rationale for the proposal

The rationale underpinning this proposal is reflective of the materialist explanation for health inequalities set out in the *Black Report* (DHSS, 1980). The materialist explanation considers health inequalities as the consequence of uneven income distribution and the concomitant difference in both access to goods and services, and in the exposure to health risks. Within the dataset, Kaplan (2002) draws attention to the role of "historical, cultural, and political-economic processes" (p.24) that have shaped the inequitable distribution of income in society, and describes health inequalities in terms of "a combination of negative exposures and lack of resources held by individuals, along with systematic underinvestment across a wide range of

human, physical, health, and social infrastructure" (p.24). Kaplan (2002) thus calls for "upstream policies" that can work to offset this lack of resource by increasing the income of lower socioeconomic groups (Table 8).

Table 8. Proposals for policies to reduce socioeconomic inequality

Citation	Exemplar quotes
Kaplan (2002)	Figure 2 clearly shows that increasing income improves health the most among approximately the bottom third of the population. Thus, upstream policies that increase the economic resources of the bottom third of the population through employment policies, education and training, or increases in minimum wages or tax credits would theoretically increase the health of that segment of the population and decrease socioeconomic inequalities in health. Similar benefits might accrue from provision or subsidization of childcare or housing costs, or other costs that fall disproportionally on the poor. (p.20)
Ndumbe-Eyoh and Moffatt (2013)	Interventions are classified as upstream interventions if they include reform of fundamental social and economic structures and involve mechanisms for the redistribution of wealth, power, opportunities, and decision-making capacities. Upstream interventions typically involve structural and system-level changes. (p.6)
SmithBattle (2012)	Reducing childhood poverty requires upstream policies that: provide a genuine safety net that protects families against poverty; improve education for children and adults; raise the minimum wage; expand the Earned Income Tax Credit (EITC) for low-income workers; and invest in job development and training for low-income mothers and fathers. (p.449)

Across the dataset authors called for policies of this nature in different ways, from loose articulations of action on the social determinants of health, to detailed policy critique. For example, SmithBattle (2012) provides a critical account of US state policy that aims to address the "major social problem" (p.444) of early childbearing. In line with the texts presented in Section 5.3, the concern of the author is how current policy works to situate both blame and responsibility with the individual, while simultaneously erasing or denying the existence of social and economic inequalities which shape life opportunities for young women. The political, and indeed the public narrative, is also said to position teenage and single mothers as simply lacking in "mainstream values and aspirations" (p.445), thus explaining their willingness to engage in early childbearing. Such perspectives result in policies which, instead of working to address underlying socioeconomic inequality, merely "prod and punish welfare recipients to attend school or work", without any attempt

to address the educational and employment barriers faced by "already disadvantaged and poorly educated mothers" (p.448). Thus, the author is calling for policies such as the minimum wage, tax credits, and investment in both job development and training to improve the opportunities for low income parents with a view to reducing socioeconomic inequality (Table 8).

Effects of the proposal

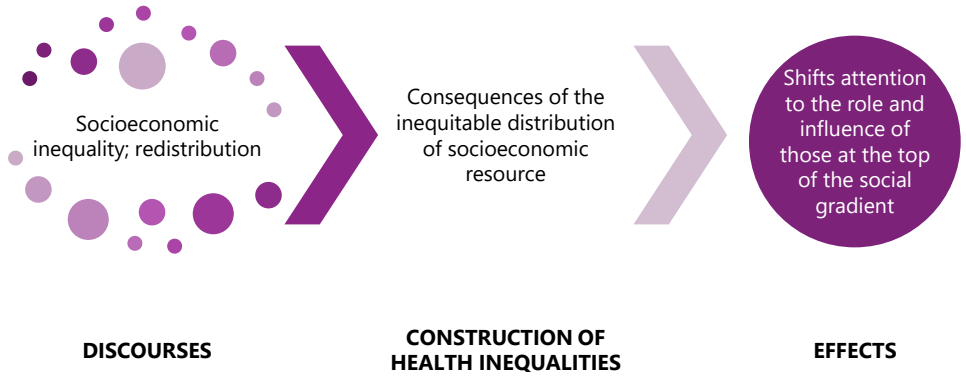
The primary effect of employing a redistributive discourse is that it shifts focus away from the lower tiers of society to consider the picture of income and wealth across the whole population. In doing so, this discourse serves to reposition those in the top tiers of society as directly implicated in the generation and maintenance of economic inequality, and as a consequence, health inequalities. From the earliest days of the *Black Report*, through subsequent major health inequalities reports, there have been repeated calls to address socioeconomic inequality. However, it is the World Health Organisation's (WHO) report from the Commission on the Social Determinants of Health which is said to have gone further than any other WHO publication in explicitly highlighting the role of socioeconomic inequality (Whitehead & Popay, 2010). In their text entitled "Swimming upstream? Taking action on the social determinants of health inequalities" Whitehead and Popay (2010) commend the content of both the global commission's report, and Marmot's *Fair Society, Healthy Lives* (Marmot et al., 2010). It is however suggested that within both reports, detail is lacking on how exactly one is to swim 'upstream' and tackle "countervailing forces driving inequalities" (p.1235). The authors cite Vince Navarro's critique of the global commission's report, which outlines that the report touches on "the need to redistribute resources, but it is silent on the topic of whose resources, and how and through what instruments" (p.1235). Additionally, Whitehead and Popay (2010) suggest that what is needed is closer scrutiny of macro policy and indeed for "political leaders to acknowledge what and who is generating and making inequalities worse" (p.1236). Over and above any other discourse presented within this chapter, it is the redistributive discourse that opens up the space to ask more difficult questions about the structures and mechanisms sustaining the current social and economic order.

Summary

An overview of the components of this proposal are presented in Figure 5. In sharp contrast to the construction of health inequalities in Section 5.3.1, the authors here are treating health inequalities as symptomatic of more fundamental socioeconomic

inequality. The goal is therefore not oriented around alleviating specific instances of inequality, but rather taking steps to bring about social reform through the redistribution of social and economic resource. This perspective, unlike other proposals, brings into the frame the need to understand the current economic system and distribution of private and public resources. It positions those at the top of the socioeconomic gradient as playing an active role in maintaining current levels of inequality through their influence at the level of government and, in particular, their influence over economic policy.

Figure 5. Components of the reducing socioeconomic inequality proposal



5.3.3.Proposal 3: Implement interventions that can bring about a change in social norms

The final proposal identified in the dataset was that of implementing interventions that work to target and change social norms. Two articles in particular employed the language of the upstream parable in the context of calling for a more nuanced understanding of hidden structures which work to shape exposure to risk, and risk behaviour. Both articles focused on the role of gender norms in shaping the HIV/AIDS epidemic and provided detailed critiques of the mismatch between efforts to reduce the epidemic, and the forces driving the spread of disease. As highlighted in the Introduction to the thesis, the materialist/structural explanation for health inequalities is a two-sided coin. This proposal, to implement interventions that can bring about a change in social norms, could perhaps be said to represent the structural side of the explanation, which considers the role of social position and related psychosocial factors in shaping health outcomes (DHSS, 1980). Exemplar quotes calling for greater consideration of social norms in intervention design are shown in Table 9. It is important to highlight that both texts included here situated their

proposals against a backdrop of profound economic inequality, and as such are closely related to the previous proposal of reducing socioeconomic inequality.

Table 9. Proposals for actions that account for social norms

Citation	Exemplar quotes
Drake and Gahagan (2015)	As such, it is problematic for HIV-prevention interventions to act on misguided assumptions about gender. For instance, Robertson (2003) asserts that changing men's attitudes about health-seeking should not rely too heavily on promoting men's health through female relatives, as this serves to reinforce the impression that real men are unconcerned about health and that health is a female domain. Efforts should be focused on challenging harmful gender stereotypes and constructs to address the underlying structural gender-based drivers of new HIV infections. (p.1278)
Gilbert (2012)	Despite increasing emphasis, of late, on the development of gender-sensitive technologies, Jewkes (2009: 37) claims they are 'unlikely to make much difference because they will not address the underlying construction of masculinities and femininities that makes such interventions necessary in the first place'. She strongly argues that 'broader transformative programmes that link promoting gender equality, economic and social empowerment and preventing sexual risk taking are also needed' (ibid.) […] The main claim is that women's (and men's) perceptions of themselves, their relationships and sexuality, have been shaped by the 'social' such as the historical legacy of apartheid in the form of poverty, poor educational attainment, lack of opportunity and high youth unemployment. (p.69)

Rationale for the proposal

The rationale expressed by the authors for this proposal is that our current reliance on models of individual behaviour change, which situate the locus of control within the individual, fail to account for the contexts in which people are expected to enact the behaviours recommended in health promotion interventions. Drake and Gahagan (2015) for example, highlight the role of power imbalances in undermining health promotion interventions premised on weak theorisation of empowerment. The authors illustrate the point using the example of a woman attending a sexual health seminar. In this instance, it is suggested that she may leave the seminar feeling "empowered", armed with new knowledge and skills. However, in her home life she may find herself still "economically dependent" on a male partner and thus may "face forced, unprotected sex without the option to use any of her tools of empowerment" (p.1280). The authors employ the same analogy as SmithBattle (2012), suggesting that "empowerment does not exist in a vacuum", and so to effectively empower women, strategies are needed that can work to address

inequitable power relationships. For clarity, I must highlight that at points in this text Drake and Gahagan (2015) seem to equate working 'upstream' with prevention generally. For example, they suggest that if health promotion programmes and interventions manage to successfully realign themselves with their founding principles then "HIV-prevention interventions will work 'upstream' of health issues, not just 'downstream' once an HIV diagnosis has been made" (p.1271). However, from a more thorough reading, it is evident that the thrust of the text is certainly not that any preventative intervention is acceptable. The authors are calling for a more considered approach to intervention development that demonstrates robust insight into the social structures and norms that shape risk and behaviour (see also Table 6).

The two examples provided in Table 9 focus on the role of gender, and gender inequality, in shaping power relationships. However, there were examples across the dataset of other instances where addressing social norms and stigma were highlighted as necessary to adequately tackle health inequalities. For example, Ndumbe-Eyoh and Moffatt (2013), in their review of intersectoral action for health equity, identified a gap in the literature, noting that "none of the included studies that focused on racialized communities addressed the issue of institutionalized racism" (p.10). Finally, in a somewhat atypical example in the context of health inequalities, Alberga et al. (2016) put forward proposals to address what they see as a fundamental cause of health inequalities: stigma and weight bias experienced by people belonging to the social group of "larger bodies" (p.3).

Effects of the proposal

The effect of employing a social norms discourse is to reposition individuals as part of complex contexts which work to shape risk exposure and behaviour. While acknowledging the importance of macro-policy in shaping underlying economic conditions, this discourse also brings to the fore the role of social structures which work to undermine health promotion interventions. In contrast perhaps to the two discourses already presented in this chapter, the effect of this discourse is not so much to look beyond the individual to target the contexts in which they live, but rather to better understand the relation between individuals and their contexts, and theorise appropriate action. Additionally, the proposals put forward in the previous sections tended to situate action in many ways at the level of macro and central government policy. However, Gilbert (2012) illustrates a route through which action at the level of the individual can work 'upstream' in the long-run. Extending the typology first put forward by McKinlay and Marceau (2000), she maps action onto

a matrix with *individualism-collectivism* on one axis, and *natural science-holistic view* on the second axis. Action situated within the social philosophy of individualism, but with a holistic view of health, is categorised under the heading of "upstream individually-focused activities" (p.64). The example provided to illustrate the point is "micro-financing to impoverished women in rural areas" (p.64), an initiative which works through alleviating economic dependence on men. In this example it is clear that both gender inequality and economic inequality are closely intertwined, and one could argue that such an initiative could just as easily be included with actions to reduce economic inequality (Section 5.3.2). It is however my interpretation from the texts, that the primary objective of these initiatives is to address power imbalances due to gender inequality, through the mechanism of strengthening economic independence.

In contrast to the discourses presented earlier in the chapter, which call for action of an altogether different kind, it seems that by employing a social norms discourse here, the authors are putting the onus on healthcare professionals to revisit and revise the theoretical underpinnings of their health promotion interventions. Drake and Gahagan (2015) for example, highlight the problem of interventions which aim to promote men's health through female relatives, thus actually reinforcing underlying drivers of HIV infections (p.1278). A additional point, of particular relevance to this thesis, is Gilbert's concern that her call to relocate the social in health promotion would be met with the criticism that to be effective in impacting the spread of HIV/AIDS would require "curing all social ill first" (Gilbert, 2012, p. 68). In fact, the author's objective is the opposite of this, and she sets out to illustrate how efforts can be reoriented to harness "the 'social' *at all levels* (my emphasis)" and thus lead "to the ultimate adoption of an 'upstream' approach" (p.75).

Summary

An overview of the components of this proposal is presented in Figure 6. Health inequalities, while set against a backdrop of socioeconomic inequality, are constructed as the consequence of inequitable power relations between individuals and groups in society which work to shape health outcomes, and also work to mediate the effects of health promotion interventions. Drawing on discourses of social norms and stigma illuminates the complex relations and interactions within which people live. Thus, these discourses serve to challenge healthcare professionals to revisit their theories of change to account for these wider social contexts. Importantly, such discourses also work to highlight the potential role of poorly

theorised health promotion efforts in compounding and exacerbating the detrimental social norms that sustain health inequalities.

Figure 6. Components of the social norms proposal

5.4.Problem 2: Methodological dogmatism

The second thread of the upstream counter-discourse relates to the problem of methodological dogmatism, which has important implications for how we evaluate the effectiveness of actions, and thus shapes efforts to reduce health inequalities. Across the dataset the problem was primarily articulated with reference to the role of evidence-based medicine and evidence-based policymaking in reinforcing and reproducing the study of individual-level behaviour change. The authors highlight anxieties that, within this dominant paradigm of knowledge production, it would seem that "remarkably little 'works'" (Asthana & Halliday, 2006, p. 578). However, they go on to suggest that it is not that hardly anything works, but that the methods used are unsuited to accurately evaluate policies reflective of the proposals set out in Section 5.3. In their text calling for a social movement to bring about policies to reduce health inequalities, Wallack and Thornburg (2016) employ an interesting quote from Thomas Pynchon, which in many ways seems to sum up the problem outlined here: "If they can get you asking the wrong questions, the answers don't matter" (p.938).

5.4.1.Proposal 1: Embracing methodological pluralism

The proposal then, as one might expect, is to extend the traditional paradigm to include alternative forms of knowledge production. The particular focus for authors was to critique the current evidence hierarchy which positions the randomised controlled trial and systematic review at the top. Citing earlier work from Whitehead

et al. (2004), Asthana and Halliday (2006) support the call for "the creative assembly of an evidence 'jigsaw'" (p.588) using qualitative as well as quantitative evidence, along with historical evidence and natural policy experiments. The authors also highlight the role of approaches with a greater focus on "context and process" (p.592), such as those employing realist evaluation and complexity theory. Any suggestion that the inclusion of more diverse data sources is an exercise in "lowering the bar in regard to admissible research" (p.588) is refuted, and rather the authors conclude that such research can both retain a strong empirical basis while simultaneously allowing for the evaluation of a wider range of policies and interventions, namely those that go beyond individual-level behaviour change. Exemplar quotes calling for methodological pluralism are presented in Table 10.

Rationale for the proposal

As highlighted in the earlier parts of the thesis, one of the primary critiques of action to reduce health inequalities is 'lifestyle drift'. 'Lifestyle drift' is described as the tendency for researchers and practitioners to start off with a broad recognition of the need to take action on the material determinants of health, but which in the course of implementation results in interventions that focus largely on individual-level factors (Popay et al., 2010). For all authors, one of the main driving forces of 'lifestyle drift' is the paradigm of evidence-based medicine/policymaking.

The text by Smith and Kandlik Eltanani (2015) supports the theory that the need for policies and interventions to be evidence-based results in limited support for more redistributive action. The aim of their study was to examine the extent to which there was consensus about the types of policies needed to reduce health inequalities. 'Upstream' policies were described as those which involved some form of redistribution e.g. "progressive systems of taxation, benefits, pensions and tax credits" (p.10). The study findings demonstrated that there was a clear consensus among researchers that redistributive policies would have the most significant impact on health inequalities. However, when asked to judge policy actions on the strength of the available evidence, researchers were more likely to support proposals oriented towards reducing lifestyle risks. Quoting a participant response to the survey, they highlight how difficult it can be to "persuade agencies to provide serious funding for the kinds of upstream interventions that would create opportunities for the generation of the evaluation evidence that is needed" (p.15). As such, the authors concluded that the need for policies to be "evidence-based" was actively contributing to the problem of 'lifestyle drift' (p.15). Similarly, Orton et al. (2011) suggest that

the "evidence-based policy culture" (p.5) makes it difficult to defend both advocating for, and implementing 'upstream' policies. The paucity of evidence to support more 'upstream 'policies to reduce inequalities in priority public health conditions was attributed by Bambra et al. (2010) to "the fact that downstream (e.g. lifestyle) interventions are more readily linked to outcomes and are easier to identify, implement and evaluate" (p.503).

Table 10. Proposals for advancing methodological pluralism

Citation	Exemplar quotes
Asthana and Halliday (2006)	Such concerns have given rise to both a quest to improve the process of systematic review and a search for alternative strategies. Such strategies advocate methodological pluralism, with most of the leading health inequalities researchers also emphasizing a need to shift from the current focus on downstream policies (i.e., policies focusing on specific risk factors at the individual level, such as smoking cessation) to upstream policies targeting the wider determinants of health such as income distribution, employment, education, access to important services, and laws and regulations pertaining to health-damaging exposures… (p.578-579)
Waters et al. (2008)	This includes focusing greater attention on ways of integrating evidence from a range of sources and on best ways of using what evidence is currently available, while remaining aware of its limitations. Inherent within this is the need to consider further the contribution and value of multiple forms of evidence to the evidence base rather than a stringent focus on ranking evidence by more traditional scientific measures. …Accordingly, exploring ways of incorporating diverse evidence sources into systematic reviews, together with a realistic view of the scope, strengths and limitations of such evidence, needs consideration if public health is to make an effective contribution to impacting health inequalities and the social determinants of health. (p.221)
Whitehead and Popay (2010)	Both the Global Commission report and the English review also pointed to the crucial role for greater citizen participation in policy and science in the pursuit of greater health equity. This requires revitalised ways of evaluating policies with potential to address the social determinants of health inequalities that allow for the joint creation of citizen and scientific expertise. This would produce not just a more inclusive and democratic form of science, but a more reliable, valid, effective and context rich science better able to inform policy and social action. (p.1236)

Effects of the proposal

In employing a discourse of methodological pluralism, authors are positioning those with the purse strings as unwilling to support research beyond the evidence-based

medicine/policymaking paradigm, while also positioning researchers who remain committed to traditional approaches as playing an active role in reinforcing a status quo detrimental to the study of health inequalities. Pearce (1996, p. 697) for example, in reminiscing on the values of traditional epidemiology and the population approach, blames the lack of government interest on the lingering influence of Margaret Thatcher and her famous statement that "there is no such thing as society, there are only families and individuals". Pearce (1996) also suggests that epidemiologists "either through choice or through necessity, have tended to go 'where the money is'" (p.679), resulting in a proliferation of research that endeavours to tackle health inequalities through targeted action at the level of the individual. To overcome these barriers, the author calls for a multidisciplinary approach to the study of health inequalities, with a focus on "using appropriate methodology rather than making the problem fit the method" (p.682).

An additional implication of the methodological pluralism discourse is the positioning of the public within the model of knowledge production. In their critique of the role of government and those at the top end of the social gradient in shaping economic policy, Whitehead and Popay (2010) highlight the difficulties in analysing the health impacts of such policy, which is both "complex and not amenable to experimental design" (p.1236). The authors suggest that there is a need to generate more public support for such work, while also developing models of "greater citizen participation" in the "joint creation of citizen and scientific expertise" (p.1236). Such approaches would overcome traditional challenges of decontextualised knowledge production, and provide more valid and contextually rich knowledge that could better inform action to reduce health inequalities.

Summary

Across the dataset, authors typically used the language of 'upstream' to refer to policies, interventions, and actions. However, in reading the texts it became evident that the authors were simultaneously using the upstream counter-discourse to bring to light oppositional and dominant discourses which were actively working to limit the support and implementation of these 'upstream' actions. In this case, the discourses under fire were those of evidence-based medicine/policymaking. The authors suggest that these approaches systematically work to undermine efforts to generate knowledge and evidence for actions and interventions beyond individual-level behaviour change. Some authors were particularly scathing of academics who were seen, for the purposes of their career, to 'follow the money' and thus effectively

reinforce a dominant paradigm that is failing in the study of action to reduce health inequalities. Employing a discourse of methodological pluralism, the effect is to shift the focus from traditional indicators of robust research and challenge researchers to consider alternative methods, with a focus on context and process, and indeed embrace the idea of more active citizen engagement in both shaping research priorities and contributing to rich, contextually relevant knowledge and evidence.

5.5. Problem 3: Lack of insight into systems and social change

The final problem identified within the dataset could be described as a problem of workforce capability. The anxiety for these authors was that despite the general consensus that people know what needs to be done to reduce health inequalities, there is a lack of knowledge and insight into how best to bring about change within both systems and society. Additionally, the concern is that the dominant discourses outlined above, of biomedical individualism and evidence-based practice, have created a cohort of researchers who feel that in order fulfil their role as objective and value free scientists, it "is sufficient to conduct research and publish the findings" (McKinlay & Marceau, 2000, p. 31). To illustrate the point, these authors reflected back on the sanitary reform era and the actions of the "putative father of epidemiology" John Snow, who, on discovering that the Broad Street pump was the source of the spread of cholera, quickly acted to remove the handle from the pump. The wry suggestion is made that "he should instead have returned to his office and written memos to valued professional colleagues (in other words, he should have submitted his findings to peer review)" (p.31). The suggested problem then, is that it is simply no longer sufficient for researchers to work as diagnosticians in pointing out and explaining health inequalities, but rather they need to take an active role in social and political action to reduce health inequalities.

Other authors however were not quite as critical of researchers and practitioners and placed the blame not on a lack of interest, but rather on a lack of consensus and guidance as to what active involvement in social change would look like for professionals working in health. Smith and Kandlik Eltanani (2015) for example, suggest that despite a general consensus about what needs to be done to reduce health inequalities, "there has been little attempt to examine what advocating for more egalitarian policies means in practical terms" (p.6). Similarly, Butterfield (2017) argues that despite the proliferation of conceptual tools to assess and analyse problems related to health inequalities, significant gaps in knowledge exist,

particularly with respect to understanding "mechanisms for upstream change" (p.4). Unsurprisingly, there was no 'silver bullet' approach identified within the sample to address this problem. Here I present three different proposals identified across the texts which set out how we can engage in more fundamental social reform and bring about the actions outlined in Section 5.3.

5.5.1.Proposal 1: Develop political literacy and advocacy skills

The first proposal identified in the dataset was that of developing skills of political literacy and advocacy. Exemplar quotes calling for capacity building of this nature are shown in Table 11.

Rationale for the proposal

Returning to McKinlay and Marceau (2000), the rationale for upskilling the workforce with the tools of political literacy and advocacy becomes soon becomes clear. Speaking in the context of the United States (US), the authors suggest that in the future, when it comes to the types of policies described at the outset of this chapter, successful implementation will not depend "on the increasing effectiveness of our interventions or on the sophistication of our research methods (although these are obviously vital), but on what an ever-changing US state will countenance" (p. 30). In addition, the authors highlight the added challenge that due to the increasingly influential role of private interests, the state has "lost some of its ability, or willingness, to act on behalf of and protect the public health" (p.30). As such, for McKinlay and Marceau (2000), viewing public health as a "sociopolitical activity" is long overdue (p.27).

For Falk-Rafael and Betker (2012), in their study of nursing action to reduce health inequalities, socio-political activity was justified in terms of social justice and ethics. The authors highlight, in no uncertain terms, the challenges facing nurses pursing an equity agenda. They describe health inequalities as "social injustices that become engrained in the fabric of society" and describe the role of government in sustaining the status quo through "slick marketing of oppressive ideologies, such as neoliberalism"; systems of rewards which, for large groups in society, work to effectively "buy their silence"; and political apathy which is rife in Western democracies (p.98). Thus, as illustrated by the quote in Table 11, public health nurses in this study viewed advocating for social justice as an "ethical imperative" (p.99) of their work, distinguishing between engaging in the day-to-day work of tending to people 'downstream', while simultaneously working 'upstream' through advocating

for equitable policy. Additionally, the authors highlighted that in instances where nurses could not engage in advocacy in their work setting, they often participated "in political advocacy on their own time, either alone or together with colleagues, or by calling upon their professional nursing organization for action on an issue" (p.108). As mentioned in Chapter 2, many authors employ the language of the upstream parable in the context of reminiscing about the 'heroic age' of public health during the sanitary reform era. Here Falk-Rafael and Betker (2012) are no different when describing what they see as a necessary return to "the social and political activism of Nightingale and early North American nursing leaders" (p.99).

Table 11. Proposals for political literacy and advocacy

Citation	Exemplar quotes
Falk-Rafael and Betker (2012)	Nurses advocated for policies that would promote health equity by ensuring equity in distribution of societal resources at whatever level was necessary, from corporate board rooms to school boards and at municipal, provincial, and sometimes national levels of government. They fought for the policies that would provide equitable opportunities for health, such as food security, housing, and sufficient income; healthy, safe, supportive, and inclusive environments; and accessible transportation. In so doing, they engaged in an intricate dance of meeting basic needs downstream, either directly or indirectly, through linking people with existing resources and moving upstream to advocate for healthy public policy. As one nurse phrased it, "I believe that it's a kind of trombone slide—that it's like the imperative of our discipline." (p.107)
Willen et al. (2017)	In schools of medicine, dentistry, the allied health professions, and public health, exposure to this approach can help cultivate health professionals who feel compelled to participate in upstream efforts to advance social justice, especially in the health domain. To make a difference, these health professionals will need a robust appreciation of the ways in which power asymmetries influence health vulnerability. They will also need to be sensitive to the complexities of context, attuned to the subjective experience of the people and communities they serve, and willing to collaborate across sectors and disciplines in mobilising for social justice. Crucially, health professionals must also have a keen understanding of how equity in health is fundamentally "a political challenge, not merely a technical outcome". (p.974)

The rationale for political action put forward by Wallack and Thornburg (2016) is in the context of new insights from the field of epigenetics, which they say "challenges us to rethink the very nature of what we mean by upstream thinking" (p.936). Epigenetics is defined here as how the environment "literally gets under our skin, creates biological changes that increase our vulnerability for disease, and even

children's prospects for social success, over their life course and into future generations" (p.935). This process is explained in terms of the "double hit" where the "first hit" is described as the "biological embedding and vulnerability" that is established from the experience of previous generations. The "second hit" refers to the "hostile environments marked by racial and other discrimination, inequality, and social disadvantage that creates constant wear and tear on human systems", and thus compounds the already established biological vulnerability (p.937). The authors suggest that a focus on these developmental origins is the "ultimate social and health equity lens" because it shines a light on "how life history, sociology and biology combine to create lifelong prospects for health and social success at the earliest stages" (p.936). However, to effectively address these truly root causes and improve early life conditions "fundamental 'upstream' strategies" are required (p. 938). Like others, the authors suggest that the magnitude of change needed to achieve this goal "will require the kind of political will that can only be found within the energy of a powerful social movement" (p.938).

Effects of the proposal

Due to the dominance of neoliberal thinking, the authors here suggest that it is no longer sufficient to expect the state to work in the best interests of the public and public health. Indeed, the influence of private interests and the free market are said to pose such a challenge that there is a need, now more than ever, for professionals to bring to light the negative impacts of the current economic and political model and advocate for action to reduce health inequalities. Positioning health professionals as having a mandate to improve their political literacy and advocacy skills was evident across the texts. A notable example comes from Willen et al. (2017) who employ a quote from Ilona Kickbusch to articulate their concern that "meaningful action on the structural and political determinants of health will be possible only when public health professionals have "a much better understanding of how politics works and what politics can achieve"' (p.974).

In response to this call to action, these authors propose a combination of two different perspectives to provide a more robust conceptual framework to guide advocacy efforts. The first perspective is that of 'syndemics', which "investigates synergistic, often deleterious interactions among comorbid health conditions, especially under circumstances of structural and political adversity" (p.964). The second perspective advanced is the right to health. The objective of the authors is for action to go beyond traditional approaches such as those "anchored in philosophical claims (like health

equity) or animated by appeals to empathy or compassion (like humanitarianism)" and instead utilise the "firm legal ground" on which a health and human rights approach stands (p.966). The authors provide a number of case studies to illustrate how "a human rights strategy informed by a syndemics sensibility would unfold in practice" (p.970). One example describes the Australian government's violation of the rights of incarcerated migrant children. The authors outline that a combined approach would first involve translating legal obligations and standards into meaningful dialogue for a multi-disciplinary team of stakeholders. Using their own knowledge and expertise, combined with a legal perspective, such a team could "collaborate in clarifying the complex constellation of factors that contribute to syndemic suffering" (p.970), and thus work collaboratively to pressure politicians to take action and disrupt the negative feedback loops between identified factors. The role of all stakeholders with a mandate for health then is to actively engage in such strategic collaboration that is "principled, evidence-based, and designed to achieve structural and political change" (p.965).

Summary

The authors contributing to this proposal see future challenges not in terms of knowledge and evidence production, but rather in terms of generating the required political will to implement what they see as truly 'upstream' policy. The proposals are framed using discourses of social justice, ethical responsibility, and rights-based approaches to health. In employing these discourses authors are situating professionals as having a moral responsibility to engage in social and political advocacy to bring about action to reduce health inequalities. Additionally, authors are challenging professionals to embrace more robust frameworks that can help to guide advocacy efforts by providing, for example, legal foundations upon which to build social movements.

5.5.2.Proposal 2: Develop skills of transformative action

Although closely related to the proposal for political literacy and advocacy, this second proposal of developing skills of transformative action is embedded within a slightly different set of discourses. Transformative action is described by Freudenberg et al. (2015) as action that goes beyond the traditional approach of mitigating the impacts of the inequitable allocation of power and wealth, to bring about a fundamental redistribution of resources. At first glance, the proposal here is very closely aligned with that set out in Section 5.3.2, but as we will see, the focus

is not oriented towards providing recommendations for specific policies, but rather outlines the *process* of successfully bringing about resource redistribution. Exemplar quotes illustrating the proposals for transformative action are shown in Table 12.

Table 12. Proposals for transformative action

Citation	Exemplar quotes
Amaro (2014)	Recent efforts based on the role of place and health are revisiting the important roles of social capital, collective efficacy, community organizing, and empowerment of community residents as agents of change for improving community conditions that impact health. Most commonly, place-based initiatives such as those addressing obesity have targeted changes in public systems and policies that negatively affect the health of disenfranchised communities, using community-building principles and strategies. (p.964)
Freudenberg et al. (2015)	Health educators working in state and local health departments have an opportunity to contribute to more upstream practice. By forging alliances between campaigns for improving living conditions and public health and documenting the process and impact of such campaigns, they can help to create the data, evidence, and coalitions that can expand the foundation for interventions that redistribute the living conditions that support health and health equity. (p.52S)

Rationale for the proposal

Freudenberg et al. (2015) provide a detailed rationale for the need to reorient efforts towards a model of transformative action. Like others, these authors highlight the dominance of biomedical and behavioural paradigms in shaping traditional practice; the difficulty of meeting the demands for evidence-based practice and policy; and the role of powerful elites in working to block and resist redistributive action. In light of these challenges, the authors highlight that actually "no systematic framework is available to assist health educators (our focus here) in finding their way upstream" (p.46S). Using three examples from the US which reflect the principles of transformative action, the authors reflect on the learning from each to map out how such "upstream approaches seek to change the political processes and power imbalances that fundamentally drive the living conditions that produce health inequality" (p.S50).

The first and most distinctive characteristic of transformative action is that it takes as its starting point an "underlying social problem" and begins with an analysis of the "role of power in creating and perpetuating a problem" (p.50S). In doing so, actors present novel framings which serve to "articulate the deeper causes of the

problem" (p.50S). The cases described in the text involved campaigns to increase low wages, prevent mortgage foreclosures, and prevent exposure to air pollution. Across each of the campaigns, the lead actors were "grassroots coalitions" (e.g. coalitions of labour unions and community groups) who have "taken on entrenched business interests and sought to expand democratic participation" (p.48S). The role then for professional actors is as a support act "providing evidence of harm, evaluating control strategies, and expediting access to policy makers" (p.51S). While acknowledging the barriers to such partnerships, the authors justify the call to action in light of the benefits to be gained. For example, it is suggested that established coalitions can over time become a more powerful authority to force reallocation of resources, beyond what could be achieved by health professionals acting on their own. Additionally, such coalitions are said to open up a "deeper toolbox of strategies and activities than either partner can offer alone", while also generating a "workforce of participatory researchers who can assemble a more diverse portfolio of practice-based evidence" (p.51S). Like Falk-Rafael and Betker (2012) in the previous section, the authors suggest that such alliances are not new but merely a reinvigoration of the public health of old which, through social activism at a local level, achieved fundamental sanitary reforms (Section 2.2).

The text by Freudenberg et al. (2015) was the most detailed and developed account of transformative action within the dataset. Two other texts however, while perhaps not going as far as Freudenberg et al. (2015) in their recommendations, demonstrated similar perspectives that go beyond calls for professional advocacy to encourage a new way of working *with* people affected by the inequitable distribution of resources. Amaro (2014), in a short commentary calling for place-based approaches to achieving population health and health equity, suggests that there is a need for public health to revisit community-building principles and strategies that can support community residents to become agents of change (Table 12). The author goes on to suggest a model of "academic-community partnerships" (p.964) as an exemplar approach. Similarly, Storey-Kuyl et al. (2015) reflect on the move within a local maternal and child health service from individually focused action to a population-focused, place-based model. The authors outline the steps in the transition, from selecting pilot neighbourhoods, through to developing and evaluating neighbourhood-level interventions. The initiative was said to necessitate "a more flexible community-level participatory approach requiring skills such as advocacy, facilitation, and collaborative leadership—approaches that facilitated coalition development and community capacity building" (p.2331).

Effects of the proposal

While all three texts employed some form of participatory discourse to justify their proposals, they are certainly not a homogenous group. The outlier perhaps being the account provided by Freudenberg et al. (2015), which describes a role reversal for communities and public health professionals. Here, established grassroots coalitions are the driving force behind campaigns and it is the coalitions that have clear ownership over the objectives and strategy. In contrast, while both Amaro (2014) and Storey-Kuyl et al. (2015) draw on discourses of participatory approaches, it is implied that the responsibility and ownership over the action remains with the professionals and their institutions. Additionally, there are notable differences in the language used between the texts to describe the communities with whom it is recommended that public health professionals work. For example, Freudenberg et al. (2015) position actors in the grassroots coalitions as "activists and reformers" (p.50S), while Amaro (2014) for example speaks of "agents of change" in "disenfranchised communities" (p.964). Such differences have important implications for how participatory discourses position groups and shape their roles within coalitions.

Despite this difference however, all proposals worked to position professionals as having a gap in their skillset. Freudenberg et al. (2015) map out the steps that they see as needed to for professionals to transition from their existing skillset within the traditional approach, to developing skills specific to transformative action. For example, in the domain of assessment it is suggested that practitioners need to move beyond being able to "collect and analyze data on existing health needs and health inequities" to having the required skills to "assess power dynamics and identify windows of opportunity to support facilitators and remove barriers to policies that promote health equity" (p.51S).

Summary

Across the texts, authors drew on participatory discourses to situate action that aims to work *with*, rather than on behalf of local groups and organisations affected by the inequitable distribution of resources. However, the nature of participation varied across the texts from citizen control in the case of Freudenberg et al. (2015), through to partnership for both Amaro (2014) and Storey-Kuyl et al. (2015). For these authors, it is suggested that to fully embrace an 'upstream' approach to reducing health inequalities, capacity building in the skills of transformative action is required.

5.5.3.Proposal 3: Develop insights into systems change

The final proposal which forms part of the upstream counter-discourse is that to bring about the types of policies described in Section 5.3, actors need to develop a better understanding of how systems work. This call is perhaps reflective of what McKinlay and Marceau (2000, p. 32) had in mind when they proposed that public health workers "deserve to get somewhere by design, not just by perseverance". In contrast to the proposals of political advocacy and transformative action, the focus here is on understanding and exploiting leverage points within systems to bring about fundamental change and social reform. Exemplar quotes illustrating the proposal for a systems perspective are shown in Table 13.

Table 13. Proposals for embracing a systems perspective

Citation	Exemplar quotes
Carey and Crammond (2015)	In coding to Meadow's full twelve leverage points, we found several powerful but underutilised leverage points. Few recommendations argued for changes to rules in the system. Rules define the boundaries, or scope of the system. When dealing with inequalities in the social determinants of health, rules become critically important. A simple example of this is how much wealth we allow individuals to accumulate. If this is unlimited, disparities are free to widen. If we cap the amount of wealth any individual can posses [sic], we stop growth at the top end of the social gradient. As Meadows contends, "If you want to understand the deepest malfunctions of systems, pay attention to the rules and to who has power over them". In our example, these rules are taxes that favour the wealthy. (p.8)
Butterfield (2017)	Consistent with thinking upstream's original premise, the goal of BUMP Health is to facilitate nurses' critical analysis of the gap between inequities and the systems obligated (through mandate, mission, or money) to reduce them. To reverse the magnitude of inequity fueled by the concentration of wealth, health care, public health, and social systems will need to reassess what they do at a fundamental level. Upstream work requires the level of conceptual discernment needed to see, challenge, and change the status quo.

Rationale for the proposal

Just two texts within the dataset focused on how new insights for reducing health inequalities could be generated by employing a systems approach. Firstly, Carey and Crammond (2015) applied the concept of "system leverage points" (p.2) to recommendations within major health inequalities reports. The authors wanted go beyond the traditional focus on examining "areas or levels" targeted by

interventions, and instead examine how the action itself is conceptualised within reports (p.2). To do this the authors used two frameworks that describe the effectiveness of different leverage points in a system. For example, the most effective leverage point is the "deepest held beliefs" (p.2) of a system, followed by system goals, which are closely aligned to system beliefs. The least effective leverage point is changes to physical elements in the system. As it is easiest to intervene at the least effective leverage points, it was perhaps unsurprising to find that the majority of recommendations in the health inequalities reports targeted physical elements of the system. However, it was noted that later reports (Marmot et al., 2010; Marmot et al., 2008), provided recommendations which targeted the goals and beliefs of systems. This finding is reflective of the comments from Whitehead and Popay (2010) in Section 5.3.2, where the authors commend these more recent reports for shining a light on the mechanisms sustaining socioeconomic inequality.

Of particular interest to this analysis however, were the authors' reflections on the extent to which the upstream-downstream dichotomy could be mapped onto the systems frameworks. Within the text, "upstream change" was described as "change within government and policy" (p.5). However, when employing a systems perspective, the authors found that conceptualising upstream-downstream as levels in a system became less useful. Rather, it is suggested that actually the "power of an intervention comes not from where it is targeted, but rather how it works to create change within the system" (p.9). Using the example of the "joined-up government" (p.8), the authors illustrate how even when interventions are targeted 'upstream' at the level of government, the adaptive and self-organising properties of the system can cause such interventions to "wash out" and "have little effect' (p.8). These insights are said to have important implications for "what effective action on the social determinants of health looks like" and the question is posed: "should 'upstream' action seek high leverage points, such as the goals of the system?" (p.9).

The second text to employ a systems perspective was Butterfield (2017). The motivation of the author here is that "many systems, through acts of either omission or commission, obscured pathways to large-scale change" (p.4) thus making it difficult for practitioners "to identify mechanisms for upstream change" (p.4). Drawing upon the work of Carey and Crammond (2015), the author presents the newly developed Butterfield Upstream Model for Population Health (BUMP Health). The model is intended to be process-oriented and work to turn "nurses' eyes toward system changes that are powerful enough to yield improvements" (p.5). Like

Carey and Crammond (2015), the author discusses the influential role of system beliefs in shaping action, and put forward one possible approach to targeting these beliefs. Highlighting the disparity between the size of the nursing workforce, and its "sphere of influence" (p.7) when it comes to decision-making within organisations, it is suggested that to bring about a change in the beliefs that "dwell at an organization's center" (p.7), greater participatory involvement of nurses, and indeed other professions, is needed.

Effects of the proposal

While both texts are grounded in very different contexts, the action orientation of a systems approach discourse results in similar calls to action for the respective target audiences of the texts. For Butterfield (2017, p. 9), the concern is around providing a framework for the profession of nursing to tap into its full potential and play a stronger role in shaping the ideas that influence health policy, and which as a consequence have such a profound impact on both nurses' own practice and the people with whom they work. Additionally, by employing a systems approach discourse, the author is challenging the profession to engage in "revealing hidden structures and processes in a system" that knowingly work to create "health risks that will be borne by others" (p.6). Similarly, Carey and Crammond (2015) employ the discourse to challenge researchers and practitioners to become more intimately familiar with the highest leverage points in systems, i.e. the core beliefs and rules of systems, which operate to reinforce and reproduce growing health inequalities.

Summary

Employing a systems perspective is proposed here to assist both researchers and practitioners in developing a much sharper insight into the nature of our actions, and their potential to bring about more fundamental changes within systems. Akin to the redistributive and social norms discourse, this perspective serves to reorient our focus away from specific interventions or target groups, to examine the complex and interacting components of the systems which operate to shape the inequitable distribution of the determinants of health.

5.6.Conflicting or unclear uses of 'upstream'

In the sections above, I have endeavoured to present a clear and coherent account of my Foucauldian inspired analysis of the upstream counter-discourse. However, before concluding the chapter, I would likely to briefly highlight here aspects of the dataset that were not a fit with the more clear-cut proposals presented above. The

reflections shared here are not intended as a criticism of the texts, but rather an effort to illustrate the sometimes ambiguous use of the language of the upstream parable within the academic literature. Three examples are shown in Table 14, which I will discuss in turn.

Table 14. Conflicting or unclear use of 'upstream'

Citation	Exemplar quotes
Mabhala (2015)	Interventionists' views of inequalities in health favour upstream population-based activities associated with tackling core determinants of health inequalities, while non-interventionists favour activities associated with encouraging individuals to make healthier choices and take responsibility for their own health. (p.1) Two contrasting views on how inequalities could be tackled emerged in this study. Some proposed a population approach focusing on upstream preventive strategies, whilst others proposed behavioural approaches, focusing on empowering vulnerable individuals to improve their own health. (p.4)
Orton et al. (2011)	The most important determinants of health and health inequalities have been demonstrated as the wider "upstream" social determinants (those things which cause ill health and the causes of these causes). Despite this knowledge, inequalities remain difficult to shift. (p.2) Public health specialists often felt unable to redress the balance away from the medical model and to divert the flow of investment from delivering services to those with an established condition to more "upstream" primary preventive approaches. (p.3)
Lorenc et al. (2013)	However, for many intervention types, the evidence base on the effect on inequalities in any health outcomes appears to be very limited. This includes many upstream interventions, such as structural environmental change and legislative or regulatory controls (other than workplace interventions). This said, some forms of upstream intervention, particularly those that involve facilitating access to healthcare, were not included in the present review. A more inclusive review would provide a fuller picture, and our conclusion that downstream interventions are more likely to produce IGIs should be regarded as tentative and provisional. (p.192)

The first example from Mabhala (2015) comes from a qualitative exploration of public health nurses' understanding of the role of public health in reducing health inequalities. Of the two quotes provided, the first clearly describes population-based activities as 'upstream', whereas the second describes a population approach as one "focusing on upstream preventative strategies". Although Mabhala (2015) does go some way towards making the distinction here between population and behavioural

approaches, use of the expression "upstream preventative approaches" could be considered generic and lacking clarity. Similarly, Orton et al. (2011) in their qualitative study of decision-makers' experiences of working to reduce inequalities in cardiovascular disease, first employ the language of 'upstream' in the context of the social determinants of health and later to refer to "more 'upstream' primary preventative approaches". As we have seen within the dataset, authors go to great lengths to distinguish 'upstream' from 'downstream' preventative actions, and explicitly articulate the characteristics of preventative actions that fit within the 'upstream' counter-discourse. It would therefore seem to be problematic to use the expression to distinguish prevention from treatment, as is implied particularly in the latter quote here.

The quote from Lorenc et al. (2013), and their umbrella review examining intervention generated inequalities (IGIs), shows that the authors excluded what they described as "some forms of upstream intervention", which are said to include interventions that aim to facilitate access to healthcare. The authors do not elaborate on their rationale for classifying such interventions as 'upstream' in light of the definition provided in main text. Although perhaps a tedious point to labour, it seems that should one be concluding, based on empirical research, that 'upstream' interventions are more likely to reduce health inequalities, and thus challenging people to reorient their efforts 'upstream', there should perhaps be a greater level of clarity in the definitions used.

5.7.Chapter summary

The purpose of this chapter has been to present my analysis of the academic literature, and in doing so present a detailed account of the 'upstream' counter-discourse. I identified three problems to which I see the upstream counter-discourse as a rebuttal or response. To counter the dominance of policies and interventions targeting individual-level behaviour change, the proposals identified within the discourse call for population approaches, redistributive action, and action which operates to address social norms which negatively impact on health. To counter the dominance of the evidence-based medicine/policymaking paradigm, proposals call for a reimagination of the evidence hierarchy. Such a reimagination is one which could accommodate modes of knowledge production that move beyond decontexualised trial designs, to account for the complexity of context in shaping the implementation, and effectiveness of policies and programmes to reduce health

inequalities. Finally, to counter what could arguably be described as a perceived passiveness on the part of the professional community, proposals call for workforce capacity building in skills of political advocacy, transformative action, and system redesign in order to bring about the level of ambitious social change needed to redress ongoing imbalances in power, wealth, and resources.

This in depth analysis of the discourse has allowed for the collation of a wide-ranging body of academic literature to produce a synthesised account of the case for reframing thinking and action to align with this idea of working 'upstream'. However, as outlined in the final section of the chapter, the language of the upstream parable as it appears in the academic literature is open to ambiguity. As such, there is a question about the extent to which the ideas that feature within this academic account translate into the interpretations of people working to reduce health inequalities. In Chapter 6, I first detail these interpretations before dedicating Chapter 7 to the process work that participants suggest is needed in order to actualise their interpretations of the upstream parable.

CHAPTER 6: INTEPRETING THE UPSTREAM PARABLE

In Chapter 5, I presented my analysis of the upstream counter-discourse as it appears in a sample of academic peer-reviewed articles. This account has been derived from authors with expert knowledge of the origins of the upstream parable, and of how it is intended to operate to reorient thinking and action to work at the root causes of health inequalities. Many of my interview participants however were not familiar with the upstream parable or its origins. As such, rather than treat the interview data as an account of a *counter-discourse*¸ I have focused here on presenting an analysis of participants' *interpretations* of the upstream parable. Importantly, it is not my intention in this chapter to make judgements about how 'right' or 'wrong' these interpretations may be in light of the content presented in Chapter 5. Rather, using the structure of the analytic framework, my aim is to provide a descriptive account of the sense-making work with which people engaged, when tasked to interpret the upstream parable in the context of working to reduce health inequalities. I open the chapter by introducing the participants, before providing an overview of the three main interpretations of the parable which I identified across the dataset. I discuss each of these in turn and highlight, towards the close of the chapter, some challenges or sticking points for participants in interpreting the parable. This chapter focuses solely on presenting participants' interpretations, while Chapter 7 provides an account of the process work that participants perceived as needing to happen in order to actualise these interpretations.

6.1.Introducing the participants

In Table 15, I introduce the interview participants and describe briefly how they construct the problem of health inequalities, and their interpretations of the upstream parable. Importantly, many participants held multiple perspectives on both. For clarity however, I have presented in this table only participants' primary constructions of the problem, and interpretations of the parable. As outlined above, Chapter 7 details participants' perspectives on the process work needed to realise their interpretations of the parable. These perspectives are also included in final column on Table 15. To avoid indicating participants' gender I have opted to use gender neutral pseudonyms and pronouns throughout the thesis.

Nine of the eighteen interview participants were familiar with the expression 'upstream', or the upstream parable, prior to taking part in the interview. Seven of

the nine participants who were unfamiliar with the idea felt that, on hearing the parable, they could equate it with a particular way of working. Two participants however, Kiran and Pat, while having clear thoughts on the problem of health inequalities, did not equate the parable with particular actions or interventions. While Kiran had come across the term 'upstream', they said that they hadn't been able to glean exactly what it meant:

> Kiran: No, you know to be honest, I've heard about it, usually read about, but what, what it actually means is…it means nothing, on the other hand about inequalities, that's…I have some ideas, from the work I'm doing, from…data I'm looking at, from the project I'm leading on, so, but, to be honest, no upstream is, does it mean you know…working with people you know at a higher level in the organisation, in the hierarchy, am I don't know, people in academia, in NHS …I'm not sure…

On hearing the story, Kiran did identify some similarities with another analogy that they had heard at a recent event on global conflict.

> Kiran: …they used a tree so the branches, and the roots, [gesturing] and the conflict in between you know so, in the conflict do we see the leaves and the branches you know as a… the result of what happened down at the bottom of the roots, so it's like very similar *(Me: It is similar yeah)* so without understanding what the roots are doing for the branches, then, the branches may die and disappear and we are unable to do anything except maybe pour a little bit of water now and then you know…

Despite identifying this similarity, Kiran did not distinguish particular actions as being 'upstream' in nature.

Pat, on hearing the story, interpreted it in terms of the implications for the individual working to pull people out of the stream:

> Pat: Ah…what comes into mind is that, is that the person that's constantly, if it, if it is that same person, are going to be totally exhausted and not be able to do it, they'll, they'll either collapse with exhaustion or they'll just say, hey, for my own good I think I better just go…

While not interpreting the parable in terms of particular ways of working, both participants did however make suggestions about the nature of action needed to reduce health inequalities, and these are synthesised into the account presented in Chapter 7.

Table 15. Overview of interview participants

Participant	Primary construction of 'health inequalities'	Familiar with expression or parable	Interpretation of the upstream parable (Chapter 6)	How to actualise interpretations (Chapter 7)
Alex: A researcher looking at how people from low income and black and minority ethnic groups experience a particular type of hospital service	As inequitable uptake, and benefit from healthcare interventions across different social groups	No	Working to address the root causes of why different groups don't avail themselves of, and benefit from, healthcare interventions	Address barriers to meaningful patient and public involvement to increase involvement of hard-to-reach groups
Ellis: A researcher looking at a particular subgroup's experience of a health promotion intervention	As inequitable uptake, and benefit from healthcare interventions across different social groups	Yes	As any type of preventative intervention which is suitably tailored to ensure equitable benefit across all groups	Greater involvement of target groups in designing health promotion materials
Fran: A researcher who has been involved supporting research projects across the collaboration	As inequitable uptake, and benefit from healthcare interventions across different social groups	No	As engaging with organisations at a strategic level to change policies and practices that could improve equitable uptake of services	Raising professional and public awareness of socioeconomic inequalities in health

Participant	Primary construction of 'health inequalities'	Familiar with parable	Interpretation of the upstream parable (Chapter 6)	How to actualise interpretations (Chapter 7)
Jyoti: A researcher looking at the differential uptake of a public health intervention	As inequitable uptake, and benefit from healthcare interventions across different social groups	Yes	As revising the delivery of public health interventions to remove barriers to equitable uptake and benefit	Engage in long-term evaluation efforts to capture the legacy effects of community initiatives
Kerry: A practitioner looking at the differential uptake of a public health intervention	As inequitable uptake, and benefit from healthcare interventions across different social groups	No	As revising the delivery of public health interventions to remove barriers to equitable uptake and benefit	Greater involvement of target groups in designing health promotion materials
Tuli: A practitioner involved in work looking at use of a particular hospital service	As inequitable uptake, and benefit from healthcare interventions across different social groups	Yes	As ensuring that health information and messages are delivered in such a way as to meet the needs of the target audience	Ensure adequate representation from different social groups

Participant	Primary construction of 'health inequalities'	Familiar with parable	Interpretation of the upstream parable (Chapter 6)	How to actualise interpretations (Chapter 7)
Bernie: A public advisor involved in a range of research studies across the collaboration	As reflective of the uneven distribution of social, economic, political, and environmental determinants	Yes	As assuring the prerequisites for health for all, and action that can build social capital and support people to take a more active role both in their own lives and in social change	Support people with the right qualities and skills in communities who can build alliances for health
Beverly: A public advisor who has been involved in research on the re-organisation of health services	As the consequences of poverty and the challenges that come with poverty	No	As action that builds on people's existing social networks to maximise their social resources to improve their lives, and thus improve the lives of the next generation	Address barriers to meaningful involvement of hard-to-reach groups and support front-line workers in their efforts to reduce the negative effects of poverty
Lindsey: A practitioner involved in a range of research studies across the collaboration	As the consequence of the wider determinants of health in deprived areas which may act as the underlying factors influencing health behaviour	Yes	As working with communities to find out what they feel needs to change in their communities and environments that would improve their health	Ensure adequate representation and involvement from people affected by decisions in their communities

Participant	Primary construction of 'health inequalities'	Familiar with parable	Interpretation of the upstream parable (Chapter 6)	How to actualise interpretations (Chapter 7)
Cam: A researcher who is looking at access and uptake of a service across different socioeconomic groups	As intertwined with inequalities in other domains (e.g. gender inequality, inequalities in educational attainment)	Yes	As social policy which supports educational attainment from early years and works to address ongoing inequalities related to protected characteristics	Raise public awareness of the origins of health inequalities and the possibility for change
Dee: A researcher working on a community-based public health project	As an inherently political problem reflective of the current economic model and associated government policy	Yes	As lobbying local and national government to implement policy that works to improve the 'upstream' determinants of health inequalities	Develop skills of the academic and practice workforces to effectively advocate for egalitarian social and economic policy
Erin: A researcher working on a community-based public health project	As reflective of the uneven distribution of social, economic, political, and environmental determinants of health	Yes	As moving beyond behavioural interventions to address the social determinants of health inequalities	Work in a systemic way and share information/evidence with people who do have the power to make changes in domains beyond health

Participant	Primary construction of 'health inequalities'	Familiar with parable	Interpretation of the upstream parable (Chapter 6)	How to actualise interpretations (Chapter 7)
Chris: A practitioner looking at people's experiences of a hospital service	As any unfair variation in uptake/experiences of health services due to individual factors (e.g. socioeconomic status) or organisational factors (e.g. postcode lottery)	No	As moving towards secondary and primary prevention to keep people out of hospital	Raise professional awareness of health inequalities agenda
Jamie: A practitioner working on an evaluation of a community-based initiative	As differences between geographic regions in indicators such as crime rates, housing, obesity levels, schooling	No	As any early intervention or prevention activity	Maintain improvements in cross-sector working and information sharing
Oli: A researcher looking at inequalities in care for a particular health condition	As differential uptake and benefit from healthcare interventions	Yes	As any form of preventative intervention.	No specific actions described

Participant	Primary construction of 'health inequalities'	Familiar with parable	Interpretation of the upstream parable (Chapter 6)	How to actualise interpretations (Chapter 7)
Val: A public advisor involved in a community-based public health project	As occurring in areas that experience high levels of transient populations and the challenges that come with this	No	As preventative action through education and changing attitudes	No specific actions described but Val did highlight challenges to actively engaging community residents in local initiatives
Kiran: A practitioner looking at the differential effects of a public health intervention	As the better uptake of public health initiatives by higher income groups	No	The parable didn't resonate with Kiran	Raise professional awareness of health inequalities agenda
Pat: A public advisor who has been involved in a range of projects across the collaboration	As occurring in areas that experience high levels of transient populations and the challenges that come with this and as the neglect of certain health conditions	No	The parable didn't resonate with Pat	Meaningful and transparent consultation with the public and appropriate governance procedures

6.2.Configuring interpretations

I identified three main interpretations of the upstream parable across the dataset. Six participants thought about working 'upstream' primarily as designing equitable health services and interventions, six thought about it as working to address the social determinants of health, and four participants thought about it as prevention and early intervention targeted at particular groups (Figure 7).

Figure 7. Three interpretations of the upstream parable

In the Introduction to the thesis I summarised theoretical debates surrounding health inequalities from the academic literature. Within this literature, and indeed in the qualitative literature synthesised in Chapter 3, there appears to be an implicit consensus about an agreed definition and problematisation of health inequalities. However, in applying the analytic framework to my dataset, it became clear that there were multiple constructions of the problem of health inequalities. As such, in order to fully understand how participants were interpreting the upstream parable, I first needed to clarify how they were thinking about the problem. A quote from the interview with Alex perhaps best captures this point. In responding to my reflection that depending on the nature of your work it isn't always clear how best to get to root causes, Alex replied:

> Alex: Well, it's hard, you're saying the root cause, the root cause of what, just health inequalities as a big, massive, I mean that's a big spectrum all in itself, the root cause of what, the fact that there is health inequalities or the root cause of health inequalities in one instance?

In the sections that follow I have therefore opted to first present participants' constructions of the *problem* of health inequalities. By clearly establishing participants' starting points in making sense of the problem, it is then possible to configure interpretations of the upstream parable to illustrate the discourses within which different ways of constructing the problem are situated, along with the implications of different perspectives for subject positions and proposals for action.

6.3.Designing equitable health services and interventions

6.3.1.Discursive constructions of health inequalities

For six participants, health inequalities were constructed as the potential for different social groups to experience inequitable opportunities to avail themselves of, and benefit from health services. Exemplar quotes illustrating this perspective are shown in Table 16.

Table 16. Inequitable opportunity to benefit from healthcare

Participant	Exemplar quotes
Alex	I think health inequalities on a massive scale to me just says that there's an inequality in the access and resources in healthcare in different groups, amongst different groups of people…
Jyoti	I started to then look at the literature and the difference in the kind of health inequalities of that group and why there might be some differences and why they're not attending and could they be to do with some of these other factors rather than just the fact that everybody gets equal opportunity and they just don't attend as much for some reason, so within that literature search I started to understand a little bit more about why people might not be attending and how socioeconomic status might be influencing that a little bit or…the distance or the language barriers, and, that was probably my basic introduction to health inequalities.
Kerry	…and then you, if you look at cervical screening, the younger age groups 25 to 30, their rates are going down and, one of the reasons they think is that maternal impact so their mum hasn't been for cervical screening, so then, they're not educated in the families then to see it as an important thing to do so then they don't go…so there's that side of it…

When Alex posed the question "the root cause of what?", I asked how they thought about health inequalities. The first quote above demonstrates that for Alex, health inequalities are intimately linked with healthcare, and the problem is framed in terms of inequality in access across different groups. Likewise, reflecting on their introduction to health inequalities, Jyoti describes the problem in terms of attendance

rates across social groups. Jyoti highlights the potential for socioeconomic status to influence attendance, and also draws attention to the role of language barriers for non-native English-speakers. When asked about the extent to which health inequalities featured in their work, Kerry provided a number of different examples to illustrate how they constructed the problem. In the example shown above, Kerry draws attention to the inequitable uptake of cervical screening services across socioeconomic groups and outlines the theory explaining differential uptake. Low levels of maternal education are said to impact both on mums' perceptions of the importance of cervical screening, which then in turn shapes the perceptions and behaviours of their daughters.

While Chris interpreted the parable primarily in terms of targeted prevention, they actually constructed the problem of health inequalities as any variation in patients' experiences of health services. In particular, Chris highlighted the role of protected characteristics in shaping their perspective on the problem of health inequalities.

> Chris: I did find, yeah, it's much easier, when I was doing, when I was doing the [project], the ones where you can tick a box, the ones where you can go right, well that's, that's a designated criteria, age, race, disability, they are so much easier to sort of say that's a…but there are inequalities built in probably to, I don't know, all sorts of ways that we, that we don't contemplate…

To illustrate this point, Chris employed the example of an initiative that was being carried out in emergency departments (EDs) for patients who are hard of hearing or deaf. They suggest that in such an example "you can see where the inequality in their care, in ED is, because they're, just the consultation alone, you're not getting a full history taken, you're not, so that kind of gets addressed because there is this real, obvious, inequality". Similarly, while not the primary interpretation of the upstream parable for Cam, they also acknowledged the relation between characteristics protected in legislation and the problem of health inequalities (Equality Act, 2010).

> Cam: …but it was the 2010 inequality Act and then the 2012, those ones it's like, they're working hand in hand, you find they are impacting on addressing the health inequalities, but they are, something to do with being inclusive in terms of ethnic background, sexual orientation on the social side of things, but on the outside, when you come to it, it means those people, who are, maybe before were being segregated they are now being included more within health practices.

6.3.2.Discursive constructions of working 'upstream'

In light of this construction of the problem of health inequalities, working 'upstream' was understood as working to address the underlying reasons why different groups may have inequitable opportunities to avail themselves of, and benefit from, health services and interventions. It was possible to further stratify this interpretation into three different strategies: (1) removing barriers, (2) tailoring health promotion messages, and (3) changing institutional processes. I will discuss each interpretation in turn using specific examples provided by the interview participants.

1. Removing barriers

The first strategy identified in the dataset was that of removing barriers to uptake and benefit. Exemplar quotes illustrating this perspective are shown in Table 17.

Table 17. Removing barriers to equitable uptake

Participant	Exemplar quotes
Jyoti	I think for me, that upstream action is to ensure that everybody does get equal opportunities by taking those other things into consideration like language barriers, or not having the facilities to travel to an appointment or needing to be accompanied to appointments and I think that's where I think the differences come in place, for the upstream action is you need more facilities for the population that doesn't have easy access to health, so that you can make sure that their outcomes eventually are equal to everyone else's who can attend appointments…
Alex	…and you know, they say about health inequalities and the big problem being the, you know, the access to services, or they'll put out services but nobody turns up […] I think if you were to go and speak to people and ask what they feel they needed to help them with their issues, they would tell you, they might say well actually you know, I can't make it to my local surgery, I don't have money for a taxi, or, I've got six kids to look after, I can't get out at that time, and, I've got too much to think about, I can't be doing this, I can't be doing that, maybe if somebody came to my own home, or, if somebody gave me the information in that respect, or maybe if I could go somewhere where I could take my children and they could be looked after while I have my appointment, I think those kinds of things really do help people and that's, I mean, I think that's been proved with the Sure Start centres and the children's centres…

For Jyoti, "upstream action" is described as ensuring that different groups have equal opportunity to benefit from health services through addressing issues such as language barriers or transport. To illustrate their point, Jyoti provided the example of an initiative to increase screening uptake in communities where a large proportion of the population are from black and minority ethnic groups. They describe how "some people have taken screening vans to those communities so you've kind of cut

down loads of barriers already" and additionally it was suggested that "they may have recruited nurses and doctors who can speak languages as well of that community", all of which was said to have "had a positive effect on rates". Similarly, Alex suggests that "if you're looking at root cause, to me that's saying that you want to know why, why are people not engaging with this incentive?'. For Alex, the easiest way to get the answer to this question is to "go and speak to people" and "they would tell you". Alex provides a lengthy list of barriers that may impact on people's ability to avail themselves of different health services, and also makes positive reference to the model of the Sure Start centres, which are suggested to have been successful in removing traditional barriers to engaging in health interventions (Table 17).

While the following example from Tuli is not specifically in the context of increasing uptake of health services, it provides another perspective on the barriers faced by different social groups. Tuli reflects that "when you're looking at minority groups, whether it's, I don't know, disability, race, gender, all that kind of stuff, sexual orientation, often people forget about the structural violence that they are exposed to". Of particular concern for Tuli is their perception that "we often look at minority groups and say you're not doing enough, but we never actually take stock of what they actually have to fight against". To illustrate the point Tuli uses the example of encouraging social participation or integration for wheelchair users when "none of the hotels in this area have disability accessible beds, or hoists". Like Alex, and Jyoti, Tuli is also highlighting the need for both professionals and institutions to develop a better appreciation of the challenges faced by different groups in their efforts to engage with health services and health promoting activities, and indeed work to address these.

2. Tailoring health promotion messages

The second strategy identified was tailoring health promotion messages to ensure that they were reflective of the needs of their target audience. Exemplar quotes illustrating this perspective are shown in Table 18.

Both Kerry and Tuli discussed the difficulty of ensuring that health promotion messages were culturally meaningful, rather than simply direct translations of messages written in English. Additionally, Kerry suggested that who delivers the health promotion messages can have important implications for uptake across different social groups. Reflecting on an initiative involving the fire service in promoting the uptake of bowel cancer screening, Kerry suggested that the value of

such an approach was that by "making it more personable, and non-medical" there was a greater chance of reaching people who would neither attend a clinical setting, nor take on health promotion messages in such a setting. The limitations of delivering health promotion messages through traditional routes were explained in terms of people's reluctance to perhaps hear medical advice when "they know they smoke, they know they're overweight, they know they drink too much, they just don't want to hear to it, whereas, you know, potentially from someone who's not medical, you're not going to get that, you're not going to be confronted with having to address those issues".

Table 18. Tailoring health promotion messages

Participant	Exemplar quotes
Kerry	Yeah, I think it's, it's a bi-, it's a combination you know, there's a lot, different cultures isn't there so, so what might apply for one culture might not apply to another, and, it's the language that it's presented in, and it's not just around translating leaflets and all the rest of it, because that message doesn't get across, it's got to be within their culture, and what they understand, rather than, as I say, just, this is, this is a leaflet for bowel cancer screening, we'll translate it into this language or whatever, that, half the time won't work…
Tuli	I don't know about this, if you know this, but type II diabetes is more prevalent in South Asians for lots of different reasons, but, often, health messages, get literally translated without taking into context, the cultural aspects to a person's understanding of their own health…and, I think for, you know when you think of our population being almost [x]% people of colour, I personally feel we're doing a disservice by not looking at that closer to see what can we do that's different…

Within the transcript, Tuli also draws attention to the role of health literacy in shaping capacity to accurately use health information and advice. The example that came to mind for Tuli, was that of people using throat sprays and "instead of spraying it inside their mouth, are spraying it on their neck". Explicitly articulating their perspective on the importance of tailoring health promotion messages, Tuli describes that "a key aspect of it is ensuring that you're communicating it to your target audience in a way that actually makes sense to them, it doesn't matter if it makes sense to you because you're not the one that you're trying to educate".

While Ellis interpreted the upstream parable in terms of targeted prevention, they too highlighted that in order for preventative efforts to be equally effective for all, "we need to be tailoring or developing new interventions to meet the needs of different population groups, particularly vulnerable population groups". Ellis went on to

suggest that very often national health promotion or prevention campaigns, which are universally delivered, are often "trying to be all things to all people, and what I'm experiencing is that all people aren't all people [laughing] you know, so we need sort of…more targeted, well in this case social marketing".

3. Changing institutional processes

The final suggested strategy within this interpretation came from a single participant, Fran, and was focused less on the role of practitioners in revising intervention design and delivery, and oriented more towards influencing policies and practices within institutions, which then shape frontline services and interventions. While not familiar with the upstream parable prior to the interview, Fran felt that it did chime with their work:

> Fran: It's not a term that I've heard before but when you've explained it, I, yes, it's a way in which I've worked, or currently work so I'm aware of that sort of…um…working at a more strategic level if you like in terms to…in terms of then trying to influence the operational delivery of something to bring something about in, in practice, in terms of…what really happens on, on the coal face for want of a better word, you know, so those on the shop floor, how are they acting and what are they doing, so, working more from, sort of a strategic level…

Reflecting back on their experiences, Fran suggests that you "need to go fairly upstream to be able to look at all the policies and the service procedures that they've got written down" in order to effectively influence service design and delivery. Additionally, Fran suggests that when trying to implement changes in service design, such as tailoring or revising services to ensure equitable uptake, you are dealing with things that are both "quite structurally set and quite difficult to change", while also connected to multiple other links in a chain. Reflective perhaps of the systems perspective put forward in Section 5.5.3, Fran goes on to suggest that in order to bring about effective change "you've got to look at all the links in the chain and basically rebuild the chain with this health inequalities lens within it".

6.3.3.Effects of the equal access discourse

A summary of the components of this interpretation of the upstream parable is shown in Figure 8. All participants situated their interpretation of the parable within an equal access discourse, with some participants explicitly mentioning the Equality Act (2010) and thus positioning their perspectives within an equality and diversity discourse.

Figure 8. Components of the equal access interpretation

The effect of this framing is that social groups are no longer situated as 'feckless' or uninclined to look after their own health. Rather, the fault lies with the professionals who are responsible for the design and delivery of services and the traditional overreliance on a 'one size fits all' approach. Not unlike the social norms discourse identified in Chapter 5, these participants seem to be challenging both researchers and practitioners to develop more nuanced insight into potential barriers to benefitting from health services, in order to develop more appropriate interventions that can effectively meet the needs of all groups. In calling for improved understanding of the barriers to equitable uptake, participants are also acting to position patients and the public as having the required knowledge to address current gaps and shortcomings in practice. Thus, in order to work 'upstream', and get to the root cause of inequitable uptake, participants called for improved mechanisms to establish meaningful patient and public involvement with representatives from across social groups. This proposal will be discussed in further detail in Chapter 7.

Whilst the majority of participants made reference to the role of socioeconomic status in shaping inequitable uptake, a number of participants also emphasised a range of other factors including age and disability. While all are important considerations, one potential effect of drawing on an equality and diversity discourse could perhaps be to shift efforts away from addressing socioeconomic inequality, and thus result in any action to reduce variation in healthcare experiences being considered as action to reduce health inequalities. However, as the equality and diversity discourse is supported through a legal framework in the form of the Equality Act (2010), there is arguably opportunity for practitioners to exploit a legal discourse in generating future support for action to ameliorate socioeconomic differences in healthcare experiences and outcomes, as suggested by Willen et al. (2017) in Chapter 5.

6.3.4.Critiques of the perspective

It is worth noting here that there were critiques of this perspective present within the dataset. The concern for interviewees who viewed the problem of health inequalities through a social determinants of health lens, was that ensuring equitable uptake of health services would not be sufficient to bring about a reduction in health inequalities. Dee articulates this point most clearly:

> Dee: …so the problem with the equal access agenda is that actually, so…you could, you could get equal access to health checks, well health checks are not a way to reduce health inequalities…what it doesn't do is challenge the appropriateness of the intervention, it, it allows you to design whatever intervention you want, without attending to whether what you're actually doing will potentially exacerbate the problem…

The primary concern for Dee is that situating the construction of health inequalities and working 'upstream' within an 'equal access' discourse does nothing to challenge the nature of the interventions being implemented, and their capacity to impact on health inequalities. Dee uses the example of the Making Every Contact Count (MECC) initiative to illustrate their point that regardless of how well MECC is designed, solely ensuring that "these poor people who are smoking and drinking have an equal opportunity to be told to Make Every Contact Count" will not be effective in "stopping people from smoking and drinking if they are living in crappy environments".

It is however important here to highlight that the majority of participants in this study held multiple constructions of the problem of health inequalities. Participants tended to interpret the upstream parable in terms of a *primary* construction of the problem, which was most often the way in which they encountered health inequalities in their work. However, it was evident within the dataset that the majority of participants employing an 'equal access' discourse positioned their perspectives, and their efforts to reduce health inequalities, in the context of widening socioeconomic inequality. Three exemplar quotes are provided in Table 19 to illustrate this point. Each participant clearly acknowledges the role of the wider socioeconomic context in driving health inequalities, and as a consequence limiting or undoing the potential benefits of their efforts to develop more equitable health interventions.

Table 19. Situating interpretations in the context of socioeconomic inequality

Participant	Exemplar quotes
Alex	I think you can, you can kind of get yourself in a bubble and looking at your own issues but it kind of gets you down, and I think it gets me down in my own research when you think, I'm trying to do this, I'm trying to do that, and then you think oh for god's sake, why am I even bothering, you know the bigger issues are there, you know, there's a massive inequality in economic resource etc. etc. you know how am I going to change this, change that because the issues are bigger than something I can sort…
Fran	…so looking at all of those different things and then for example, you might be working with one NHS trust and they might be redesigning one of their services so now they're trying to look at, how do we do that so there's fair access for everybody so we're not disadvantaging one group, so, that is just one service but it…if those people in that vicinity don't have access to jobs there's nothing that reorganising that health service is going to do to help them get a job, not necessarily, it might lead longer term to better health, therefore they might have a better chance of getting a job and staying employed but it's not, there's no quick fix there for actually, one of the issues is jobs and money and then they can pay for better housing, they can pay for as much heating as they want and food and etc., so, it's only one part of the jigsaw…
Kerry	I think as well, and this, this is my, personal political view, I think it's just getting worse for people, because of the government and what their beliefs are around benefits and all the rest of it, and they, they don't see the big picture, they don't understand life outside of, the political world, and their privileged world, and until that starts getting addressed, then it's very hard, from a health perspective, to address everything else, and we can all do interventions locally and all the rest of it but, that big picture needs to be addressed, and it's only going to get worse as well, because you've got that mass-, that divide is just getting bigger and bigger between the have and have nots…

6.4.Addressing the social determinants of health

6.4.1.Discursive constructions of health inequalities

For six participants, health inequalities were constructed as the result of the inequitable distribution of the social determinants of health. As the social determinants of health are wide-ranging in nature, the three exemplar quotes shown in Table 20 illustrate three different interpretations of a social determinants of health perspective.

For Lindsey, the emphasis is on the immediate social contexts in which people live, and the extent to which these contexts shape health risk behaviours. Framing health inequalities in this way, Lindsey is highlighting the need to move beyond blaming individuals, to instead take into consideration the "bigger picture" in understanding

the uneven distribution of risk behaviours. However, as we will see later in Section 6.6, despite employing a social determinants lens in understanding the problem of health inequalities, Lindsey acknowledged their own tendency to think about solutions in terms of changes in empowerment and control at the level of the individual.

Table 20. Inequitable distribution of the social determinants of health

Participant	Exemplar quotes
Lindsey	…my initial thought might be…so, somebody, people who are more disadvantaged and come from a deprived area are more likely to smoke and therefore are going to have worse health but it's about thinking about well what might be making, what might be contributing to those people smoking, I'm probably using smoking as not a very good one, but the way it's been described to me is that yeah it's their decision to smoke and to have that unhealthy lifestyle choice but actually if we look at the bigger picture there are things that might be contributing to that and levels of stress and anxiety associated with poor housing or debt or something like that, maybe alcohol is something as well that you would think of, so there's more to it than just, I'm making an unhealthy choice and therefore my health is going to be worse, there's…other things that might be contributing to that…
Cam	…for me, in my opinion anyway, I think this is quite a, complex issue which cannot be tackled in a linear fashion because it is entwined in other things, for us to succeed in health or in tackling health inequalities I think we should also involve the educational aspect of it, because for people to make maybe healthy choices, or what we would term good choices in health, you need to be educated to a certain level for you to understand the importance of why you should keep your body healthy and you know, be able to make that decision then I, I find that inequalities just don't exist in health, they are also in…the education system, so if I'm not educated enough to understand the importance of my health, how can I tackle the health inequalities, that's how I look at it.
Beverly	I mean all this thing with the housing, you think Grenfell Tower *(Me: Oh my God, yeah)* you know and it's a very stark picture of what, exactly what we're talking about *(Me: Exactly that, yeah)* in the, probably the richest Borough of London that people have been living in a death trap and everybody's going blithely along, and it's all, you know, not only that, it's stark, but it's a reality, what we have to do something about is poverty, poverty, addressing poverty, and it's not just about throwing money at things, it's the old Charles Dicken's thing isn't it, poverty and he called it want and ignorance […] it's poverty and ignorance together have to be addressed and that's education and social structure...

In light of discussions in Chapter 5, the second quote from Cam can seem counterintuitive at first glance due to the emphasis placed on lifestyle and individual choices. However, the call for education here is not in terms of health education and dietary advice, but rather a call for understanding health inequalities in terms of

educational attainment and schooling. To further illustrate the extent to which education becomes entwined with different axes of inequality, Cam uses the example of recent calls to see more "women in the boardrooms". However, as they have suggested, looking at a single domain in isolation is insufficient as they reflect, "if I don't have the qualification will I even dream of applying to be part of any boards so to speak so it has, the opportunity has to start right from kindergarten". Health inequalities are therefore understood to result both from inequitable opportunities to excel in education from the earliest years, and the ways in which educational inequalities then intersect with other axes of inequality.

The final quote in Table 20, is from an interview which took place in the weeks following the Grenfell Tower fire in 2017. Using this tragedy as an example, Beverly provides another slightly different take on the role of the social determinants in shaping the problem of health inequalities. For Beverly, the crux of the issue here is poverty and the implications of poverty in shaping life opportunities. Drawing on Charles Dicken's allegorical story of *A Christmas Carol*, Beverly clearly articulates their perspective on health inequalities as the result of society's disregard for the poor in the form of want and ignorance. For Beverly however, it is not simply a case of throwing money at the problem; two fundamental changes need to happen, changes in both education and social structure.

6.4.2.Discursive constructions of working 'upstream'

Reflective of the constructions of health inequalities presented above, I identified three main interpretations of the upstream parable. These included: (1) improving material conditions and resources, (2) improving opportunities in education and training across the lifecourse, and (3) building social capital and support networks. Unlike in Section 6.3, the multiple interpretations of the upstream parable that I have identified here are quite different from one another. As such, I have opted to provide separate summary graphics for each, and detail the effects of each interpretation within their respective sections rather than at the end.

1. Improving material conditions and resources

For Dee, Erin, and Lindsey, the upstream parable was interpreted as addressing the material conditions in which people live. Exemplar quotes illustrating this interpretation are shown in Table 21.

Table 21. Improving material conditions and resources

Participant	Exemplar quotes
Erin	So we all know that bad housing conditions impact on health, we do…and especially they affect more those who are more socioeconomically vulnerable because they might live on benefits and because if they live on benefits then they don't have any money, they will end up renting…bedsits or…they might end up living in houses in multiple occupations…ah, and the conditions of those houses are appalling right, so it's not enough with treating those people, many of these people might develop chronic stress, asthma, because of the damp conditions, so yeah it's good that when they go to the doctor, they do get treatment for those health conditions and psychological support, but they go back to their houses and still they have the same problems.
Dee	I think it's a political problem because a focus on upstream social and commercial determinants of health inequality is a political agenda and it's ah, it's a party political agenda, right, that makes it really difficult so tobacco and smoking, the public health community, academics and practitioners, all were completely happy to campaign for legislation to ban smoking but they would not dream of campaigning for legislation to ban poverty or legislation to ban inhuman working conditions, they wouldn't, they haven't, they don't do it, you know, but they pat themselves on the back because they did tobacco...

While a small number of people alluded to the need to move beyond behavioural interventions, Erin was most explicit in highlighting how this knowledge underpinned their perspective:

> Erin ...what do I understand by upstream approaches…so there is evidence that behavioural actions don't work to reduce health inequalities, a lot of evidence, so by upstream I mean tackling the root causes and the root causes are usually social, economic and political right and that's not something you can tackle by educating people to behave properly…

Dee, similarly, frames their interpretation of the parable in terms of the determinants of health, and suggests that working 'upstream' is "thinking about well, if you were to be sensitive to, to respond to upstream determinants, what would that mean for you". In contrast however to all of the other participants, Dee employs an overtly political perspective and goes on to describe 'upstream' action to reduce health inequalities as "a party political agenda". In a critique of efforts to date, Dee suggests that the greatest successes of the public health community have been limited to regulating lifestyle and behaviour while neglecting social determinants such as working conditions and poverty. For Dee then, truly embracing an 'upstream' agenda would require the public health community to engage in a more politically driven

endeavour to bring about policies that could work to alleviate the inequitable distribution of adverse material conditions.

Interestingly, across the dataset only one participant provided a tangible example of a policy change that could work to improve financial resources. In discussing the potential effects of a universal basic income, Bernie focuses less on material gains, and more on the psychosocial benefit that the security of an assured income would bring, particularly for individuals who find themselves at a disadvantage in the job market e.g. individuals who experience mental health problems or have a disability.

Bernie	…that's one approach that I think is a public, upstream public health, having universal income because if you have a universal income people can experiment and they've got security that they have got a certain amount of income coming in, so then they could experiment, they could have possibilities, they can energise people, they can take, like people that have got mental health problems, they could try a job but if they thought, if they, in the previous they had no universal income, they'd lose all their benefits, just because they tried the job and that would give them a boost so these are, what, in a roundabout way, what I'm talking about is, they're all upstream public health…

However, as we shall see, Bernie's primary interpretation of the upstream parable is more closely aligned to the idea of building social capital to bring about social change.

In summary, for participants who constructed the problem of health inequalities in terms of adverse material conditions, working 'upstream' was interpreted as action to address the inequitable distribution of these conditions. An overview of the components of this interpretation is shown in Figure 9.

Figure 9. Components of the material conditions interpretation

Not unlike earlier discourses presented within this chapter, drawing upon a discourse

of material disadvantage works to shift attention away from individuals to consider the contexts in which they live and work. Additionally, this perspective positions professionals as having an active role to play in working to address the conditions which are making, and keeping, people unwell. The proposals for action within this discourse are therefore oriented towards collaborative action, and engaging in what Dee describes as "responsible advocacy" to influence both local and national policies which shape living and working conditions. These strategies will be discussed in greater detail in Chapter 7.

2. Improving opportunities in education and employment across the lifecourse

Perhaps unsurprisingly, in light of Cam's perspective on the problem of health inequalities, working 'upstream' was interpreted as implementing social policy that could address and improve other domains which are so influential to health. Cam reflected on the major health inequalities reports of the past two decades and suggested that in the lead up to the publication of the *Black Report* (DHSS, 1980) "people were more ready to embrace government initiatives", highlighting in particular initiatives which tried to "be more inclusive in terms of education". And again in 1998, Cam reminisced on what they perceived as "such a huge embrace of people accepting that yes there was that social inequality and that would include education as well as the health sector". The influence of public support for more equitable social policy was seen by Cam as seminal in the implementation of these changes, and like Alex, Cam also makes reference to the value of the Sure Start model, which was seen as an "effort to try and address the opportunities right from the young age".

While both Fran and Tuli primarily interpreted the upstream parable in terms of designing equitable health services, both participants also highlighted in their interviews the need for actions to improve opportunities in education and employment. Fran for example, saw "one of the key things" as getting up "that educational ladder" and getting "access to opportunities that could lead to employment, not education just for the sake of it but something that's going to lead you into a meaningful job". Tuli put forward a slightly different perspective, highlighting the importance of blind applications and equality monitoring in managing unconscious bias in appointing employees. They had recently learned about an employer that wasn't collecting any monitoring data, and while the perception within the organisation was that there wasn't an issue with bias or discrimination because "nobody wants to believe that they have prejudices", Tuli

suggested that due to the lack of monitoring data "you can't really make that assertion, that there isn't an issue". Tuli went on to highlight that "often people from minority groups, don't feel it's their place to question things", and as such they are less likely to request feedback after an interview. Tuli proposed the practical solution of automatically providing all candidates with feedback following an interview in order to alleviate potential disadvantage.

Within this interpretation of the upstream parable, health inequalities are ultimately considered as manifesting in domains beyond the purview of the health sector, with participants drawing upon discourses of social mobility and equality of opportunity. A summary of the components of this interpretation of the upstream parable is shown in Figure 10. While Tuli did provide a practical example of local organisational change that could positively impact on equality of opportunity, more fundamental social change is evidently needed to facilitate improved opportunities for social mobility. As such, the effect of this perspective is to highlight the role of the broader public, and society, in shaping the nature of social policy that gets implemented, and the consequential effects on social, and health inequalities.

Figure 10. Components of the social mobility interpretation

While there are certainly similarities between this interpretation of the parable, and that of improving material conditions and resources, the main difference perhaps is the focus here on early life and the lifecourse. Such an emphasis serves to distinguish between action that can shape life opportunities to improve education and future earning potential, in contrast to actions which are oriented towards more acute or immediate improvements in the day-to-day conditions in which people live. While neither Cam, nor Fran, articulated in detail their perceptions of the role of the health sector in generating support for policies that can improve social mobility, both participants did discuss the lack of broader public awareness about the problem of

health inequalities and social inequality. Proposals for action therefore included active engagement in public debate on the topic, along with developing strategies that can work to change public perception of the drivers of health inequalities. The importance of generating public support for action was highlighted by a number of participants across the dataset and this proposal will be discussed in greater detail in Chapter 7.

3. Building social capital and support networks

The two participants who framed their interpretation of the upstream parable primarily in terms of building social capital and support networks were public advisors, Bernie and Beverly. Illustrative quotes from these participants are shown in Table 22.

Table 22. Building social capital and social support networks

Participant	Exemplar quotes
Bernie	…what we want is flourishing people and then they can build social capital, now social capital is a big upstream, where the community and your, because alienated people tend to be isolated people, so we want them to become activists and it doesn't have to be, activism, it can be any activism, it can be a hobby, or we could go into an evening class and people will become energised if they had the universal wage, believe me, they would you could have faith and hope, and people would flourish more instead of just surviving…
Beverly	I mean all those supporting structures that help people, if you, I've lived in poverty at times in my live, I'm going get upset, [laughs], that's daft, but I've lived in difficult circumstances shall we say, a long time ago…you know Maslow's hierarchy *(Me: of need?)* it's that, it's that, if you are struggling, day-to-day to survive so if you're in, in poverty and you're trying to feed your kids, if you're in a dangerous situation because of a partner or a, or you know gangs on the street or whatever, you're just surviving day-to-day, you can't possibly break through that without something supporting you, it's those sorts of social structures that I'm talking about and that is not about the petticoat police coming in and you know, telling you how to bath you baby, or give you milk tokens or what the hell, that's not enough, that's not what it's about, it's about empowering people, through their existing social networks and structures, and helping them to get to the point where they can look up over the parapet…

While Bernie highlights the value of a universal wage in assuring financial security, it is evident throughout the transcript that their primary interest is in how such an initiative could work to address the current levels of alienation and isolation experienced by people in society. Reflective of the academic account of the counter-discourse, Bernie too positions their interpretation of the parable as counter to the

influential forces working to shape how we look at and understand society. In particular, Bernie expresses profound concern over the mutually reinforcing discourses of psychology and neoliberalism, which are said to situate both the problem and the solution within individuals, thus reducing the collective capacity to come together and bring about change.

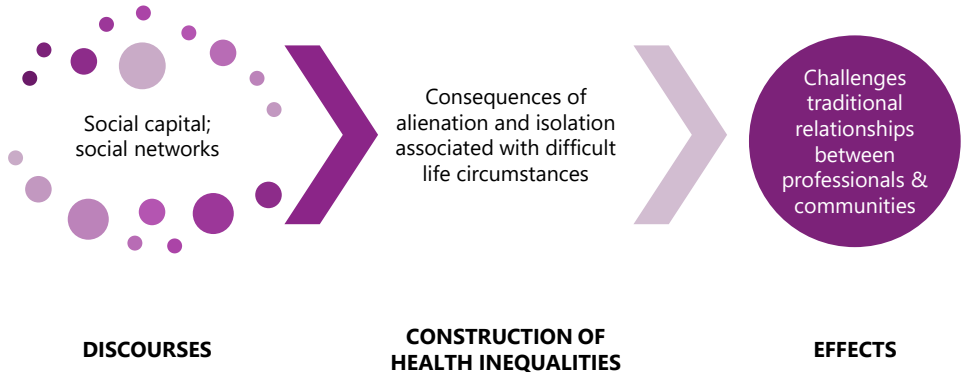
> Bernie: …so in the last 60 years, more so in the last 40 years, there's been an alliance between neoliberalism, drug companies, big pharm, and the state, the government, it's a form of social control, if you can individualise it within the individual you know you've got, the diagnostical and statistical manual, you know comes out, and DSM 5 came out in 2013 and everyone in the now world has got a mental illness, and it's not good, because it individualises, it stops people, realising they've got to, they need to come together and change things, people are angry, people are discontent, people are traumatised, people are worried, people live in misery, ah, people, you know have, you know severe mental distress but they don't actually come together to try and change things, it's all individualised…

Thus for Bernie, 'upstream' public health approaches are those which bring people together, in an active and engaged way, to work towards change in society. To illustrate this point further, Bernie uses the example of a local town that has long-standing difficulties with low educational attainment, crime, and unemployment. Bernie outlines how in the past they had recommended that "the best things you could ever do is make links" with the rest of the region, because "in places like this, they have sort of, bounded attitudes, they don't socially mix with any other groups or classes" and that it is only through "bridging" between communities that more fundamental change could be achieved.

Similarly, Beverly expressed the importance of using social networks and social resources to empower people in difficult circumstances (Table 22). Reflecting on their own experience, Beverly employs Maslow's hierarchy to illustrate that basic needs, such as feeling safe, are not being met for many people in society. Importantly, Beverly highlights that traditional paternalistic approaches oriented towards influencing behaviour and choices (i.e. the "petticoat police") will not be sufficient to bring about the necessary change in social support and social networks. However, Beverly does acknowledge the difficulties involved in work of this nature, reflecting that "I can count on one hand the people that I've seen who do make a difference". The question then for Beverly is "how do you do anything without seeming like you're coming down from some sort of ivory tower like Lady Bountiful" when trying work with "those folk that are struggling".

While both Bernie and Beverly highlighted the role of financial insecurity and poverty in shaping life circumstances, their interpretation of the upstream parable was oriented towards action that can work to bolster existing social resource and social capital in order to empower people to become active and energised citizens. A summary of the components of this interpretation of the upstream parable is shown in Figure 11.

Figure 11. Components of the social capital interpretation



Individuals and groups are positioned here as constrained by the environments in which they live, and the complicated challenges that come with these environments. However, they are also positioned as having the potential to become more active flourishing citizens with the right support, which goes beyond tokenism and paternalism, and rather works in a more meaningful and engaged way to develop relationships, and alliances, with people and communities.

Both participants provided clear and insightful accounts of the role of the cruel state and poverty in shaping health inequalities and while both constructed the problem in terms of macro social and economic problems, the proposed solutions were oriented towards pragmatic local resistance in the form of building social capital through community development. The most pressing concern then for Bernie and Beverly was the extent to which people working on the ground in communities, have both the personality and skills to be effective in their roles, and additionally the extent to which they are adequately supported by the public purse. These challenges will be discussed further in Chapter 7.

6.4.3.Summary

While all six participants here drew upon a social determinants of health perspective in constructing the problem of health inequalities, the nature of the actions advocated

were quite different across the three interpretations of the parable. Cam and Fran suggest that increased public awareness is needed to generate support for social policies to address equality of opportunity. They also suggest that there is a role to play for people working within health to contribute to public debate on the problem of health and social inequality. Erin and Lindsey argue that more collaborative action is needed to stimulate change in local and indeed national policies that shape the uneven distribution of the social determinants of health, with Dee outlining the need for stronger political insights on the part of the health sector in order to facilitate responsible advocacy. And finally, Bernie and Beverly highlight the value of supporting people on the front line to develop authentic alliances and partnerships with communities and thus contribute to improved social networks and resources.

6.5.Targeted prevention and early intervention

The final perspective that I identified across the dataset was that of targeted prevention and early intervention. Jamie, Oli, Chris, and Val were the participants interpreting the upstream parable in this way.

6.5.1.Discursive constructions of health inequalities

The constructions of health inequalities by these participants were oriented towards particular groups who may be faring worse than others. For example, Oli described their perspective of the problem in terms of "disparities in care, or inequalities in care" and provides the example of differential uptake of screening interventions by the "worried well" who "were crowding out maybe more deprived populations from being tested". Jamie takes a slightly different perspective, focusing on the stark differences in health outcomes that exist between regions. Describing their local area Jamie outlines:

> Jamie: …the difficulty is, [region] is so diverse, it is so diverse, you can get on a train at [place 1] and travel up to [place 2] and your life expectancy increases by 11 years, it is so diverse, you know, crime rates, housing, obesity levels, schooling, it's so diverse, it changes in every area you go to, and it has to be said that the further north in [region] that you go, the better everything is…

Similarly, Val saw health inequalities as most problematic in areas with transient populations who often come to an area with "so many problems, quite frequently drugs and alcohol".

6.5.2.Discursive constructions of working 'upstream'

As shown in Table 23, for these participants, the upstream parable was interpreted in terms of prevention and early intervention targeted at specific groups.

Table 23. Early intervention and prevention

Participant	Exemplar quotes
Oli	So…upstream for me it means ah, more preventative action, so…I was speaking to a friend recently who's been working on an initiative to…prevent some lung, lung diseases in rural Africa so, as opposed to waiting until ah, people come to hospital with some kind of lung infection, lung disease, instead they ah, are introducing an intervention upstream, in that, the actual disease is caused by people cooking at home using wood and in kind of enclosed environments, so, instead of using this to cook, they're introducing gas, and of course it's cleaner and ah, hopefully it will prevent illnesses later on in life so I'd see that as more of an upstream initiative whereas downstream initiatives are waiting until they come into A&E and it's already too late…
Val	The first time I saw it I thought well, it's…preventative medicine, but then when you think about it, it, it has to involve a lot more than that because you're trying to keep people healthy without having to deal with the problems when they occur, and, so, I, I see it as involving…education, changing attitudes, am, not easy because, you know, people don't, they're quite happy living the way they are and ah…it raises all sorts of issues…
Jamie	…what we've found is an awful lot of people who are lonely and isolated tend to get referred into emergency services, or referred into adult social care when they don't necessarily meet the needs or the criteria of it, whereas if they had a community intervention and they accessed local services in groups and they increased their social circle, increased their confidence in being able to talk to their family and friends and ask them for help, then crises will be averted…so it comes very, rather than saying it's upstream, it, it kind of looks like early intervention and prevention itself, as, let's look at the cause of what this is and let's get lonely people connected with the community so that the signs and the symptoms which would then be accessing the emergency services and the adult social care isn't necessarily needed at that point.

Oli provides an interesting example to illustrate how they distinguish between 'upstream' and 'downstream' interventions. The 'upstream' intervention in this instance was changing cooking approaches from wood to gas to reduce the prevalence of lung infection and lung disease. Oli also provided the "5-a-day, healthy eating education programmes" as an example of an 'upstream' intervention which "can save, save a lot of lives, help a lot of people later on in life". Thinking about the intervention ladder proposals from Chapter 5, I asked Oli during this interview if they would make any further distinction between preventative interventions that

aim to change the food environment, and interventions that relied on advice and education as the mechanism of change. Oli suggested that, while interventions regulating the food industry are "kind of moving further upstream", they are also "taking away from people's choices and liberties" and so they weren't sure "how feasible those interventions are". Therefore, for Oli, any type of preventative intervention is considering as working 'upstream', with the decision to support one intervention over another ideally being based on "which is the most clinical and cost effective" strategy. Likewise, in articulating their interpretation of the parable on first hearing it, Val suggested that it sounded to them like preventative medicine and as such would involve education and changing attitudes. Ellis, while primarily interpreting the upstream parable in terms of tailoring health promotion messages to ensure equitable benefit across social groups, also framed 'upstream' intervention as preventative action distinct from downstream treatment and cure.

> Ellis: Oh yeah, I'm very familiar with that…I liken it to a great big stream and very often the NHS is pulling out bodies at the end of the stream, you know, and it's too late then, and all of the, all of the man power, all of the resources are targeted around pulling people out too late…whereas in actual fact we need to move up the stream, to stop people jumping in the river and ending up downstream in the first place, but that I think is a massive, erm, it's like turning around a juggernaut because everything is geared towards treating people's medical conditions…and preventative services are like the Cinderella service, they don't get any resources and they are the easiest to cut back.

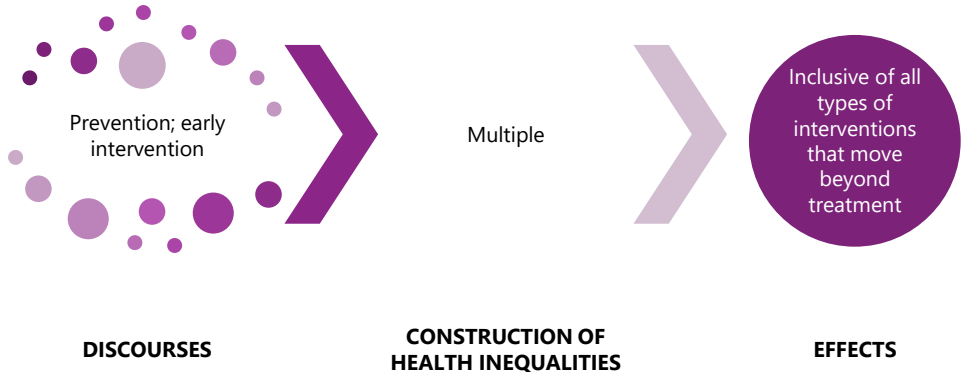
Jamie explained their interpretation of the parable in terms of another analogy. Using the example of going to the doctor, Jamie describes how often doctors tend to treat symptoms instead of finding out the cause, whereas "if they looked at the root cause of the issue, and dealt with that then you wouldn't have to deal with the signs and the symptoms". Applying this analogy to a real initiative, Jamie outlines how a local evaluation is endeavouring to go beyond the symptoms of unnecessary referral to emergency or social care services to work at the root cause of the problem, which in this case is described in terms of loneliness and isolation. Applying a health inequalities lens Jamie describes that by focusing on "quite a deprived area" in the region it is hoped that there would be "better results out of that area".

6.5.3.Effects of the prevention discourse

While participants constructed the problem of health inequalities in different ways, the crux of the upstream parable for them was in terms of preventative action, making the distinction between such actions and the alternative of downstream treatment and

cure. A summary of the components of this interpretation of the upstream parable is shown in Figure 12.

Figure 12. Components of the targeted prevention interpretation



In contrast to the perspectives presented above, interpreting the upstream parable through a 'prevention' discourse results in the inclusion of a wide range of actions that meet the criteria of going beyond reactive treatment or cure, to prevention and early intervention. For some participants, the tendency not to provide further distinctions between preventative interventions, or indeed advocate for specific actions over others, was reflective of their perspectives on the need for policies and interventions to be feasible, affordable, and indeed socially acceptable. Val for example reflected, "thinking particularly about the upstream…what can you actually do, in practical terms, that's affordable, that is going to make the difference?" Further reflections from participants on some of the challenges in operationalising a preventive agenda are discussed in Chapter 7.

6.6.Participant reflections on interpreting the parable

Sections 6.3 to 6.5 present perhaps an overly tidy picture of the sense-making work that participants had to do in interpreting the upstream parable. Additionally, while most participants endeavoured to provide an interpretation of the parable during the interviews, not everyone was convinced of its utility. Alex for example, who hadn't heard the parable before but understood it in terms of addressing the underlying barriers that prevent people from being able to avail themselves of and benefit from healthcare interventions, suggested that it was a "misleading kind of thing to say", as for them the idea was less about going *up* and more about drilling *down* to better understand the contexts in which people are living:

Alex: Yeah, and I just, I, I just think it's kind of a misleading kind of thing to say, or, it seems like to me that upstream is one of them buzzwords in looking at reducing health inequalities and I think, I don't know, there's lots of buzzwords about isn't there in healthcare, where it's just a word that's used to describe how we're going to think about how we're going to do something, rather than actually doing it…

While Lindsey found that the upstream story made sense in theory, equating it with action on the social determinants of health, they found that when thinking about different types of action to reduce health inequalities this upstream-downstream dichotomy became less helpful.

Lindsey: …the way I'm trying to distinguish it in my head is not really helping me at all because I'm thinking things that are helpful to the individual to feel empowered and have some sense of control, I'm now trying to put all the onus back onto the individual when in actual fact, it's not down, my first point was it's not all about that person making bad choices or it shouldn't all be down to the individual to, it should be down to all sorts of other things, so then I'm thinking, oh…

Lindsey also went on to say that "I find health inequalities quite difficult to articulate, I get it, but…articulating it, I'm not very good at". Likewise, Chris reflected that "as clinicians, we can cope, health inequalities in a box, if it's just that sort of inequality we need to address, whether somebody accesses it or whether they don't, whether they…they take the drug, or they don't" but that for other aspects of health inequalities "the more I think about it, the worse it gets if I'm honest".

A final point to make from Erin's interview is reflective of the challenges experienced by Carey and Crammond (2015) in applying the upstream-downstream dichotomy to system levels. Erin was the only participant to make a further distinction between what they see as 'midstream' and 'upstream' actions. Using the example of the living wage, Erin suggests that should local authorities make it a requirement that all companies holding contracts with the council pay the minimum wage, "that's midstream right…because, it's at a regional level, ideally that should be implemented nationally". Here Erin is making the distinction based on the level at which the policy is implemented, where a national, universally delivered policy would be needed to meet the criteria of 'upstream'. However, in line with the conclusions of Carey and Crammond (2015), Erin later goes on to suggest that "upstream is not necessarily in terms of levels" but rather what matters is the ability of an action or intervention to "address the root causes".

6.7.Chapter summary

In this chapter, I have presented my analysis of participants' interpretations of the upstream parable. The most important finding of this chapter is that employing the upstream parable as a form of heuristic, has brought to light the multiple ways in which participants construct the problem of health inequalities. Additionally, it has illustrated that many participants actually hold multiple constructions of the problem, which align both to 'big picture' perspectives, and more localised constructions of health inequalities which are amenable to day-to-day action and intervention. Indeed, it was in terms of these more localised constructions that participants tended to interpret the upstream parable. Importantly, some participants found that they couldn't equate the upstream parable with particular ways of working, and others felt that the parable itself was misleading and operates to obscure, rather than bring to light, the nature of action that they saw as needed to reduce health inequalities. This chapter has focused solely on presenting participants' interpretations of the nature of action advocated through the upstream parable, and so in the final findings chapter, Chapter 7, I provide an account of participants' perspectives on the process work needed in order to realise these interpretations.

CHAPTER 7: ACTUALISING INTERPRETATIONS

In Chapter 6, I presented an account of participants' interpretations of the upstream parable in terms of proposals for action. These interpretations were reflective of how participants problematised health inequalities, and for many were often closely related to the nature of the work that they do on a day-to-day basis. The focus of this chapter turns to participants' perspectives on how to actualise these proposals. In contrast to Chapters 5 and 6, which are structured according to the six steps of Foucauldian discourse analysis, this chapter is organised into five main proposals which were prominent across the dataset. In the first section of the chapter, I introduce these proposals, and also present a form of 'network map' which illustrates the relationship between these and the eighteen study participants (Figure 13). I then discuss each proposal in turn, highlighting where consensus emerged, and also highlighting contrasting or oppositional perspectives. I conclude the chapter with a summary of the key findings.

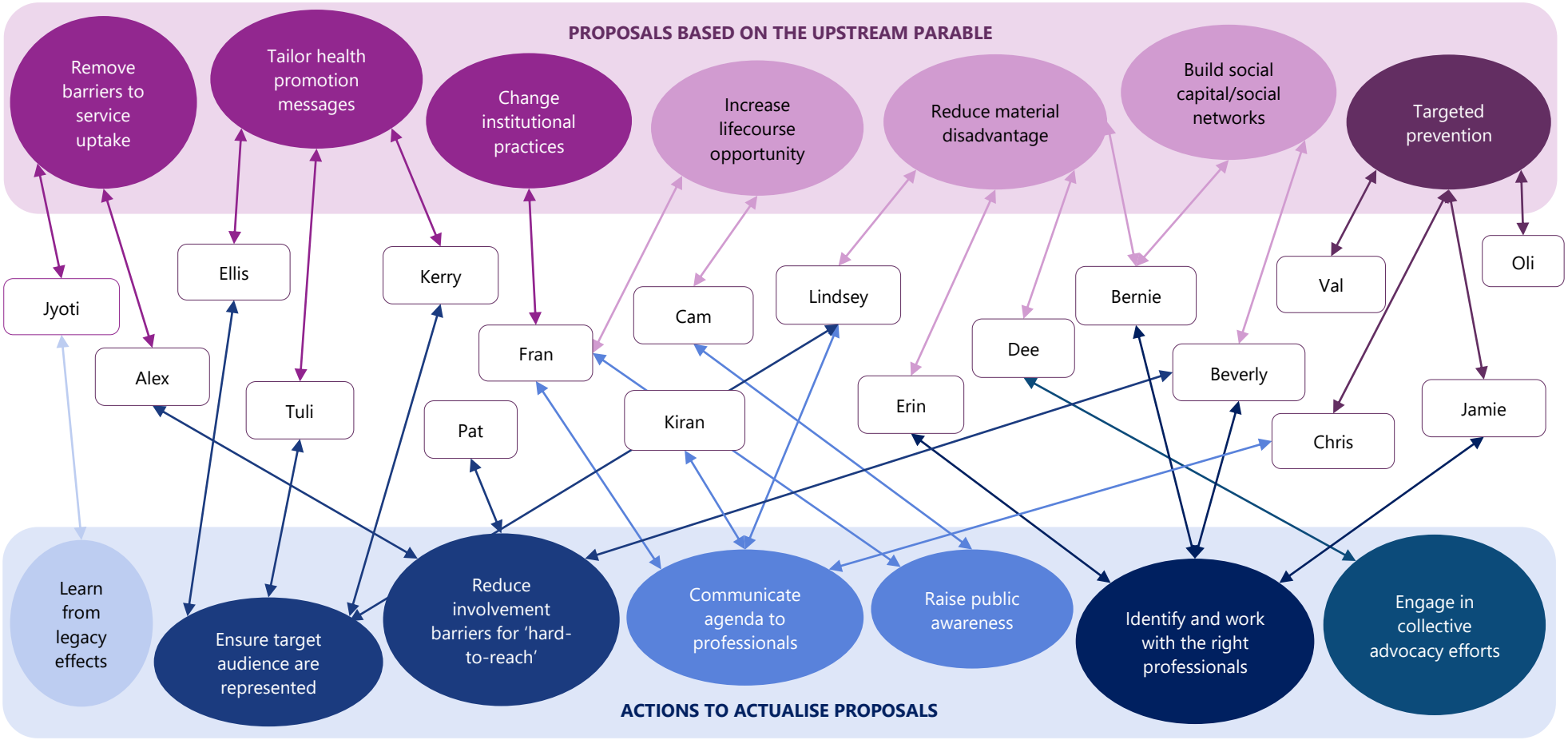
7.1.Introducing proposals

Throughout the interviews, participants drew attention to the process work needed to bring their interpretations of the upstream parable to fruition. I have organised these proposals into five main categories, three of which are further divided into two more specific proposals, as shown in Table 24.

Table 24. Overview of proposals

Speak to people and involve them in the process
• Ensure target audience is represented
• Reduce involvement barriers for 'hard-to-reach' group
Generate greater insight into the health inequalities agenda
• Communicate health inequalities agenda to professionals
• Raise public awareness
Identify and work with the 'right' people
• Identify and support people with the right qualities
• Work with the people who can help you make a change
Engage in collective advocacy efforts
Capture legacy effects

Figure 13. Relationship between proposals and participants



While it was possible in Chapter 6 to present neatly configured problematisations of health inequalities, and interpretations of the upstream parable, perspectives on how to actualise interpretations were much more cross-cutting in nature. Figure 13 illustrates the relationship between the proposals and interview participants. At the top of the graphic are participants' interpretations of the parable, with the different proposals on how to actualise these interpretations shown at the bottom. Arrows link the participants to their respective contributions. For the purposes of clarity and readability it was not possible to illustrate the full breadth of insights shared by participants here, and so I have opted to present what I have identified as the strongest or most prominent perspectives from individual participants.

7.2.Speak to people and involve them in the process

Six participants discussed the importance of effective patient and public involvement, a proposal which could be further divided into actions underpinned by: (1) an equality and diversity lens, and (2) a socioeconomic inequality lens. The former highlighted the importance of ensuring that there was adequate representation from the target audience when designing health services and resources. In contrast, participants employing a socioeconomic inequality lens questioned aspects of the current approach to public involvement, which could inadvertently work to exclude the people whose views are most needed. I will discuss each of these perspectives in turn before outlining the implications for future action.

7.2.1.Ensure target audience are represented

The three participants who interpreted the upstream parable primarily in terms of tailoring health promotion messages, all discussed the importance of having adequate representation from target audiences. As shown in Table 25, Ellis outlines that, at present, the onus is on practitioners to revise or develop their own tools and resources to ensure that interventions and services can meet the needs of a range of different groups. However, despite the efforts of professionals, Ellis articulates their concern that there continues to be a lack of involvement of the end user in these processes. Further expanding on this same point, Kerry outlines that the potential positive effect of more active involvement of the end user is a greater sense of ownership over both the processes and the outcomes, and as a consequence an increased likelihood of promoting and driving initiatives forwards.

Table 25. Ensure target groups are represented

Participant	Exemplar quotes
Ellis	…but that guidance hasn't been targeted enough so practitioners have been involved in developing their own tools, resources, so they've been very much left to doing that themselves and then that in turn, informs the guidance…erm…but for me there's been a lack of involvement from people with [characteristic] themselves in the development of guidance, and in some cases in the development of resources as well so…it's being done to them, rather than with and for them…if you get my gist…
Kerry	Yeah, it does, it needs to come, it needs to be driven by the people who it affects, rather than someone in ivory towers thinking, oh I think I'll put this leaflet together or I think I'll come up with this initiative, and I'm not saying that always happens, some people you know, they go and have the focus groups with the right people and all the rest of it, but there needs to be some ownership from the people it affects, and for them to have that authority to drive it as well…
Tuli	…because, the thing is, it's that intersectionality element as well, especially with health inequalities, and you know I was, I was talking to colleagues in public health and they were like, what do you mean intersectionality *(Me: Oh!)* exactly, I was saying, well you know, you can talk about a scale, and it could be, all, multiple layers of someone, so yes I'm a woman, so perhaps I can speak for women, I'm also a woman of colour, but I'm not black, so I would…I guess if I was, aware enough, I would remember to ensure that I said well I'm not speaking for everyone if you want to know more about, what issues, or what, the burning issues are for black communities in our area, you need to speak to them, yes, I'm a person of colour, but I can't speak for that community…

The quote from Tuli captures their own experience, as a woman of colour, often being called upon to provide insights into demographics that are less well represented within their organisation. Here Tuli is highlighting the limited understanding of the concept of intersectionality amongst colleagues, and as a consequence a potential lack of awareness of the importance of having representation from different groups. This was of particular concern for Tuli in a region with a unique demographic makeup, and as a consequence "a unique set of concerns" with which to deal. Despite the unique demographic however, Tuli reflects on the tendency to "have white men speaking on all topics", and asks the rhetorical question: "why can't you pass the mic?" One further example comes from Lindsey, who, reflected on the tendency for decisions to be made without consulting those affected:

Lindsey: …talking to the people who live in those communities that are at the disadvantage is the best way to understand what you would then put in place rather than just the people in the local authority or the commissioners deciding, we need to put that there because that's what we think.

However, as we will see in the section that follows, a number of barriers have been identified to actively and meaningfully engage with lower socioeconomic groups.

7.2.2.Reduce involvement barriers for 'hard-to-reach' groups

While Alex and Beverly interpreted the upstream parable in different ways (see Figure 13), both participants shared similar reflections on the importance, and indeed the challenge, of actively involving in both research and practice, people from different socioeconomic circumstances. Exemplar quotes illustrating their concerns are provided in Table 26.

Table 26. Reduce involvement barriers

Participant	Exemplar quotes
Alex	Yeah, and I think if they were to look at it, or go to people in communities and look at the people, and go to the areas where there is these big massive issues in health inequalities, it scares people, you know, official documents, going in, saying you need to sign this, you need to sign that, it puts people off automatically because there's that divide, you're not on the same wavelength, you're not talking to them as an equal, you're saying oh I'm the, I'm the one with the power, I'm the expert, I'm the researcher, I've got all these documents, sign the-, sign your name here and if you, if you look at people who you're trying to help, when have they ever come in, or when they come into contact with those kinds of interactions, it's always for formalities such as, you know, job centres and things and I think that might not be an issue but to me, I feel if I was going to engage and look at the root cause of the problems and I wanted to find out why this, why that, I'd first and foremost think to myself, I've got to get their trust, the people's trust to open up and talk to me about what, what are the issues and how can we solve them.
Beverley	Well, the thing that's going through my mind is about the estate near where I live and that, people, have…like in the [organisation] meetings and all these things that I've been to, have no idea, and some of the, I mean some of the people there who are involved in the projects, yes they have because they are working with people on the ground, but they're actually cushioned from it as well, I mean I know people that, you'd never ever reach, just wouldn't full stop, so it, all that, just sort of a vision of working upstream there, yeah, it's difficult…

For Alex, to understand the inequitable uptake and benefit of health services and interventions, you need to go and speak to people in order to understand the problems which need solving. Alex clearly articulates this perspective when they suggest that

"to get to the root cause of anything you have to take yourself to where it's happening". However, as illustrated in the quote above, Alex highlights that some institutional practices, which form part of the recent and increasingly formalised public involvement discourse, have actually served to make it more difficult to speak to certain groups. While not explicitly naming the official documents or practices, one could hypothesise that Alex is referencing things such as right to work checks, expense claim forms, and payments for public advisors. Although such official procedures may not be seen as a barrier for some public advisors, Alex suggests that "if you look at people who you're trying to help", it is likely that these practices closely reflect interactions with other, less positive, public sector institutions. As such, Alex suggests that professionals need to work with individuals and communities to establish relationships underpinned by trust and more equal power balances. In doing so, it is suggested that typical barriers to engagement may be reduced, thus increasing the chances of capturing a wider range of perspectives.

Similarly, Beverly suggests that despite the well intentioned efforts of professionals, it is likely that there are people whose voices and perspectives will never be heard. Reflecting on their own experience with the collaboration, Beverly highlighted a number of potential barriers to engaging in a public advisor role for people from different backgrounds. As alluded to in the quote above, Beverly was concerned about the disconnect between professionals and the communities in which they are intending to work. Additionally, Beverly went on to describe their sense that some professionals "are actually quite condescending about these people, I don't, they don't use that term because they've learned not to because they're 'PC' and they're clever people, but actually it's still there and like I said to you before, people living down on [estate] are not stupid". Beverly also discussed the extent to which institutional practices were devised to be inclusive. Despite their own efforts to challenge institutionalised ways of working, they found limited success, particularly around the use of language and abbreviations in communicating with public advisors:

> Beverly: I think genuinely when I brought some things up, like I got one document and there was a paragraph about three, three inches high and there was the odd word like "the" and "and" and all the rest were in abbreviations you know, and I mentioned it at one meeting, and they thought, oh yeah, you know we really, you know, we will try to, it's a disgrace, they all know, but you've fallen back into it because it's your own tribal language…

In light of these challenges, the concern for Beverly is that a lot of people will be put off from getting involved because ultimately, in such a setting, "you've got to be quite strong to say, hang on a minute I've got no idea what you're saying". Thus, both Beverly and Alex suggest that there is further work to be done in negotiating the interface between institutions and communities in order to break down current barriers and ensure more equitable involvement.

While Val interpreted the upstream parable as targeted prevention through changing attitudes and education (see Table 23), they also shared some reflections about their experiences of getting people involved in research activities to make changes within a community. Akin to Beverly's communication concerns, Val too suggested that at an initial meeting "they talked about everything they were trying to do and I think…they overdid it, and it came over too academic, they tried not to but it did", something which Val felt "put quite a lot of people off". In light of some of the proposals put forward in the academic account of the counter-discourse, and in particular a focus on mobilising communities to become active agents of change, Val's insights demonstrate the challenging realities of such an approach. For example, reflecting again on the initial meeting in this particular community, Val described how people "talked freely about what they felt about it all" with some expressing that they had "seen all this stuff before, people trying to do stuff, and you know, nothing happens". As such, these groups were seen to be less inclined to get involved because of the sense that "this would also go down that path". To further illustrate the level of disengagement they experienced from some community residents, Val provided the follow humorous example:

> Val: We initially, I think one of the aims was to do what we're doing but also to try and get people involved themselves, but that just hasn't happened, every person that we've interviewed, with one exception, one of mine, was not interested in taking it any further, coming along to a meeting to talk to other people, you know, some said *'Oh I, I don't want to get involved in anything like that'* , the youngest person I spoke to who was in their late twenties, unemployed and he said at the end…he said *'I don't want to get involved in anything like that'* he said, *'it's a waste of time'* he said, he said, *'not a waste of my time, it's a waste of your time'* [laughs] he says, I had to laugh he's says, *'I bet you've got a committee!'*

One final example illustrating the unique challenges of public involvement also comes from another public advisor. Pat felt strongly that the crux of making positive changes was to ensure that meaningful consultation with the public took place at every step of the process. As described in Chapter 6, the upstream parable didn't

resonate with Pat, and indeed they suggested that "actually it sounds quite grand really in some ways that we're moving upstream and I'd say, let's just be practical, let's be practical and go out", and "ask people, and make sure you do it right". For Pat, the importance of public involvement, particularly in relation to the National Health Service and health services research, was to ensure transparency, accountability, and adequate governance. However, as others have highlighted, there are numerous challenges to getting public involvement right, and during their interview, Pat highlighted a particular example of this. Pat described one experience, prior to becoming involved in the collaboration, where despite the contribution of public advisors "when it came to the final meeting, we were not allowed to sit in, now if you would have said, you can come and listen but you can't speak fair enough but we weren't even invited after we had gone out" and collected the information that informed the final decision-making. Thus, while participants were positive and felt strongly about the importance of public involvement in order to bring to fruition their interpretations of the upstream parable, there were numerous concerns identified as to how best to establish reciprocal relationships and enable meaningful ongoing engagement.

7.2.3.Implications for future action

In the context of reducing health inequalities, the effect of a public or lay involvement discourse is to position these groups as having the knowledge and insights needed to both identify and prioritise problems, and devise solutions. While unremarkable perhaps in the context of tailoring health promotion messages, there is a certain tension inherent in positioning communities and public sector institutions as allies, in order to potentially mobilise against or resist the negative actions of other public sector institutions. The lack of engagement experienced by Val, for example, serves to illustrate this point, and indeed highlights the precarious position set out for community residents who are being asked to take up the role of change agent, in light of a historical context where there has been a paucity of positive social change.

Additionally, researchers and practitioners are positioned here as both caught in a system of institutional practices that undermine the importance of relationship building, and as lacking the necessary tools and skills to extricate themselves from institutionalised ways of working in order to more effectively communicate with people from beyond their professional domain. Institutional practices, which form part of an increasingly dominant Patient and Public Involvement (PPI) discourse, are questioned for their utility in supporting the development of meaningful and

authentic relationships due to the extensive formalisation of the process. Perhaps the dominant PPI discourse at play in academic institutions at present, rightly or wrongly, positions researchers and practitioners as needing close monitoring and regulation to ensure that they do not exploit the public to achieve their own research goals. But in doing so, as suggested by participants here, such regulations could be said to result in significant barriers to involvement, thus limiting the diversity of individuals likely to take on such roles.

7.3.Generate greater insight into the inequalities agenda

The second most prominent proposal identified across the dataset was that of generating greater insight into the health inequalities agenda. While most participants felt as though they had a good grasp of health inequalities, and what actions are needed to reduce them, they suggested that these insights were not commonplace amongst professionals and indeed the public. As such, for these participants, discussions were oriented towards different strategies to address: (1) professional understanding, and (2) public support for the health inequalities agenda.

7.3.1.Communicate health inequalities agenda to professionals

While much time and energy has been invested in communicating the health inequalities agenda to professionals across the collaboration, e.g. the development of the Health Inequalities Assessment Toolkit (HIAT) (Popay, Porroche-Escudero, Sadler, & Simpson, 2015) and associated training, some participants felt that there was much more to do in disseminating these messages to the wider workforce. Two participants in particular highlighted that, in their efforts to raise awareness of health inequalities in their work, they were met with real scepticism towards their initiatives. The quotes provided in Table 27 illustrate these experiences. Chris, for example, suggested that colleagues were not open to having some of these more "difficult conversations" about factors that might be impacting on patients' experiences, or their capacity to benefit from treatments and interventions. Likewise, Kiran outlined scepticism on the part of general practitioners, who also challenged the validity of the data and the claims that were being made about health inequalities within local communities. Additionally, it seems that when these colleagues did eventually come around to the idea that there might be unfair differences in who is benefiting from public health interventions, their perspective was that this wasn't something that they could help with, it was a public health issue alone.

Table 27. Participant examples of colleagues' denial of health inequalities

Participant	Exemplar quotes
Chris	I remember speaking to some of [colleagues] about it and it was, I wouldn't say it was…naivety is not the word, but denial almost so when I tried to have those more difficult conversations about what about the patients where there's this or there's that, oh I don't, I don't really think that applies to our population, I think there's a lot of, hidden inequality, and, as a society, that's where we want to keep it, we don't, especially within, I don't know maybe it's just the environment that I work in…
Kiran	…how it was translated in my own project was that, as I told you, we had all the analysis, we did all the presentations, it became like a…is funny the right word, we would go to a neighbourhood and make a presentation and we were not sure what the reaction was going to be, you know, and one time I remember, we did the presentation and this doctor was adamant that this is a load of rubbish, you know, where did you come from, you are making it up basically *(Me: As in he didn't believe?)* he didn't believe, and he told us then, I've worked I don't know how many years, you know I have, I haven't seen any of this stuff that you are talking about…so what do you do with, with a person who is in that position as a GP, saying this is…this is nonsense, or somebody who says, that's fine, so what do you want from us, we have nothing to do with it, it's your, it's your problem, this is public health you know…

Fran presented a slightly different perspective in highlighting the lack of insight into the health inequalities agenda amongst the wider workforce. However, the critique here is not of the workforce, but rather of those people who are themselves experts in health inequalities. Fran suggests that people who understand health inequalities very well tend to assume that it a concept that is easily grasped. However, reflecting on their own experiences, Fran suggests that actually health inequalities are not particularly well understood by most people, and that often depending on the way in which the information is presented, it can serve to further alienate people who would otherwise be quite willing to engage.

> Fran: I think for me, I've come across people that think that, well health inequalities is a basic concept, I know a lot about it, not me, them, I know a lot about it, therefore, so does everybody else and it's like, actually they don't, and if you just explained it to them, they would come on board with you, it isn't that people don't want to engage with this agenda item…

Employing the metaphor of a "percolator", Fran proposes that whilst there has been extensive debate about health inequalities at the level of government policy, the lessons learned haven't been "filtering through all the layers" and down to the wider workforce. As such, reflective of their interpretation of the upstream parable, Fran

suggests that there is a need to work at a strategic level within these organisations to ensure that the knowledge around health inequalities does filter through in such a way that results in greater insights into, and understanding of, the health inequalities agenda.

In outlining their perspective on this challenge, Lindsey reflected on a recent example within their organisation where an initiative was implemented with a view to reducing health inequalities. However, follow-up evaluations showed that it hadn't made a significant difference, thus prompting people to ask if there was a clear understanding at the outset of the problem they were attempting to address.

> Lindsey: …it was decided at the beginning that this is something that would definitely work…but I don't think there was maybe the conversation about really do we underst-, what do we mean when we say health inequalities, and what do the [organisations] understand by that and do they even really get it, I think people say that they do…but I'm not so sure…

Thus, both Lindsey and Fran are highlighting a need for more effective approaches for communicating the health inequalities agenda to the wider workforce. Not unlike the suggestions from Beverly and Val in Section 7.2.2, Lindsey also suggests that even for professional staff "if it's something that's too academic, people don't get it and then it's too difficult", and so in order to "build that kind of understanding, knowledge, build that capacity" that "it's got to be at the right level and with the right messages coming through". While I didn't probe at the time as to what Lindsey had in mind when referring to the 'right level' and the 'right messages', I expect from discussions that it is about ensuring that messages are reflective of the day-to-day problems faced by, in this case the partner organisations of the collaboration (e.g. NHS trusts).

A final point on this comes from Alex, who also described meeting people who did not have a grasp of health inequalities, which they suggested was because "sometimes people are blind to it because they have never experienced it". While, as discussed above, Alex focused primarily on reducing barriers to public involvement, they also outlined how aspects of public involvement such as "co-production" and "experience-based co-design" could be useful tools in developing practitioner insight into health inequalities by ensuring that "you're actually getting the voices of those who are affected and saying to practitioners, actually this, this is what's going on, does that make sense?" While these participants were reflecting on barriers to engaging professionals in day-to-day actions that could contribute to reducing health

inequalities, participants who viewed working 'upstream' as involving changes in national health and social policy highlighted the importance of also generating increased insight and awareness of the health inequalities agenda amongst the wider public.

7.3.2.Raise public awareness to influence popular opinion

Dee and Fran for example, interpreted the upstream parable in terms of national polices that could reduce material disadvantage and improve opportunities for social mobility over the lifecourse. As policies of this nature tend to be realised only in response to popular support and political pressure, it was perhaps unsurprising to find that both participants had concerns over public perceptions, and indeed misconceptions about the drivers of health inequalities. Fran, for example, reflected:

> Fran: …because another thing that I've come across is that other people are, and I've heard people blame people, they're over eating or they're smoking or they're over drinking or why do they do that to themselves, you know, what is it, why are they doing that, because they don't understand any of the underlying issues or problems, that might lead to some of those excessive behaviours…

Likewise, Dee expressed their concern that people look at the problem of health inequalities through a meritocracy lens, thus concluding that people who find themselves at the lower ends of the social ladder are there through their own doing, or as a consequence of innate aspects of their character. It is important to note that like Beverly, this reflection from Dee was not limited to members of the public but also applied to professional staff that they had encountered in their work.

> Dee: I think some people genuinely believe that this, the reason why people are poor, and have got poor quality jobs is because they are somehow weak personalities, you know, and they, they've not got it in them to get their act together, so you might then get some kind of pity for them, you know, you won't get empathy, but you'll get some kind of warped understanding, you know, these are weak individuals…

Further illustrative quotes from Fran and Cam outlining the need to raise public awareness are shown in Table 28. For Fran, one approach to combating misconceptions about the drivers of socioeconomic inequalities is to somehow "open people's eyes" to the role of historical events in shaping, in particular, geographic variations in deprivation and health. Cam also employs a historical perspective reflecting on profound social changes that have occurred in relatively recent times. Taking the example of slavery, Cam suggests that in order for such a change to come

about people "kept talking and talking about it" until the message penetrated public opinion, and there was collective agreement that something needed to change. Thus, in order to bring about fundamental change in the current social order, Cam suggests that we need to keep talking about it, and embed the message in the minds of the public that this is an unfairness, and an injustice, that it is possible to do something about.

Table 28. Raise public awareness

Participant	Exemplar quotes
Fran	…how, in Britain we've managed to get into this system of having so much disadvantage, you know, such large populations in such large areas and so many of them, ah, you know across the country and the sort of divide between the haves and the have nots, until you kind of open people's eyes to this is what's going on and this is why it's happened, historically, you know, this is what happened in these areas, and districts that maybe, were functioning quite normally before ah…they lost a large employer or the government intervened and moved an employer away, and then there was no money, no jobs, and the area spiralled into this disadvantaged area so…
Cam	…because, well, I look at it from, I always think good always prevail, if you look at like, our, the social circumstances when slavery for example was at its peak, nobody ever thought it would end but it did and people kept talking and talking about it until, you know, people listened and it became engrained in people that it wasn't good to do that […] we try and find and solutions to solve it so I think it's the same as health inequalities, the approach, it appears like maybe we are not making any steps but I think we are…

However, as the nature of action needed to sufficiently impact popular opinion, and as a consequence shape political pressure for more equitable social policy, is beyond the purview of the day-to-day working of people situated within health, participants put forward suggestions as to who might be able to make an impact. For example, Fran identified the media as a potential tool for educating the public and suggested that, "TV is a great media, you know, putting things on soap operas like East Enders and stuff like that, making that the script, making that the theme, those are the things that start to bring it alive for a good chunk of the population". However, the media were also identified as a potentially negative player in shaping public perception and support. Kerry, for example, discussed the influential role of the press in driving the narrative around benefit claimants, where now "you've got that mentality haven't you where people on benefits are shirkers" and as a consequence people will "quite happily support the Tories, pulling people's benefits away". At the time of writing the thesis, BBC Panorama had just aired a documentary entitled Get Rich or Die

Young, which focused on differences in life expectancy across towns in the North East, with a particular focus on Stockton. While there were some positive responses to the documentary by way of raising awareness of the problem of health inequalities, others have argued that it may have concomitantly served to reinforce some of the less helpful perspectives highlighted by Fran and Dee above.

7.3.3.Implications for future action

As outlined in the Introduction to the thesis, and in Chapter 2, health inequalities have been intensely and extensively debated and discussed, particularly since the late 1970s. However, participants here have highlighted an ongoing lack of awareness and insight amongst professionals and the public into the nature and origins of the problem of health inequalities. Thus, in order to realise their interpretations of the upstream parable, which ranged from changing institutional processes to targeted prevention, participants have suggested that strategies are needed to address this gap. Firstly, health inequalities experts are positioned as having a greater responsibility to communicate messages in a way that is meaningful for a wider target audience, and in a way which ensures that messages percolate through all of the different layers of professional institutions and the public sphere. Secondly, participants have highlighted the importance of countering unproductive political and media narratives that are reminiscent of the 'feckless poor' discourse, and which thus operate to further instil counterproductive perspectives on the origins of health inequalities, and the mechanisms which operate to sustain them.

7.4.Identify and work with the 'right' professionals

Four participants discussed the importance of identifying and working with the 'right' professionals in order to bring to fruition their interpretations of the upstream parable. The two proposals in this category, while quite different, are both oriented towards finding individuals with the tools needed to bring about positive change (e.g. knowledge, skills, data, authority). The first proposal relates to Bernie and Beverly's perspectives about the types of people who are best placed to facilitate the building of social capital though developing social networks and social resources. The second proposal is specific to professional relationships, and the role of information-sharing to support action to reduce health inequalities.

7.4.1.Identify and support people with the right qualities

Bernie and Beverly both discussed, in different ways, the qualities and skills which people working with communities at the sharp end of the social gradient should possess. Exemplar quotes illustrating their perspectives are shown in Table 29.

Table 29. Support the 'right' types of professionals

Participant	Exemplar quotes
Bernie	I think what we need is a new, knock me off if this is irrelevant, we need sort of…a new type of health worker, be it social worker, be it a public health nurse or be it a public health department…or be it a nurse, or be it anybody, they need to go out into the community and live amongst the people and develop community projects with the people, form alliances with the people, form other alliances, like maybe get the trade union people involved, the community, there's a community trade unions branch…and people for themselves to start to become activists, I don't mean violent activists, passive activists, non-violent to become, start demanding change in society…
Beverly	….so you, how do you do that, how do you enable people who are going to work with those folk that are struggling, how do you enable them to do it, and how do you support them in the role as well so there's a whole other layer to that…and that parachuting down into, if you had to go and immerse yourself in that life, it's very difficult *(Me: And having the resource to support the right people I guess)* and identifying who the right people are…

As described in Chapter 6, Bernie interpreted the upstream parable both as reducing financial insecurity, and building social capital within communities. For Bernie, the way to achieve the latter was through "a new type of health worker" who could successfully build alliances within communities and support people in in demanding social change. For Beverly, their concern was that the right people are put in place to support people who are struggling. Reflective of their concerns articulated in Section 7.2.2, Beverly outlines past experiences with different professionals whom they perceived to be lacking the qualities needed to establish authentic relationships:

> Beverley: …people try, you get youth workers do it a lot, and I don't want to criticise people in any way because they are, they are well meaning and that's not in a derogatory way, they genuinely are well meaning, you get young middle class lads, from middle class families that have been cosseted, moving into areas to help people, and, I think I can count on one hand the people I know who have been really genuine about it because, not that those folk don't genuinely mean it, it's just they, they don't understand the reality of it that's the problem, so…how do you do that?

Describing the contribution of one particular youth worker who they felt had been successful in bringing about positive change within their community, Beverly outlines how they see work of this nature as "vocational". Beverly goes on to suggest that "they're rare those people", pondering that "most people I guess would get burned out by it". Expanding on this concern Beverly also discussed the ongoing budget cuts to public services and the likely impacts these must have on those people who, like this youth worker, have invested so much time and energy in certain communities, establishing networks and alliances to support and empower community residents.

> Beverly: …since all the austerity, if I can call it that, disgusting term, since all of that he's, everything has been cut down to the bone and all the things that he's been trying to do, all these years, he must want to weep at what's been rolled back…

Thus Bernie and Beverly are highlighting the need to identify, support, and value people on the ground who do have the ability to build authentic alliances within communities with a view to bringing about positive social change.

7.4.2.Work with the people who can help you make a change

The second way that working with the 'right' people manifested across the dataset was in terms of collaborative and intersectoral working. Illustrative quotes from Erin and Jamie are shown in Table 30.

During Erin's interview, we had useful discussions about the utility of distinguishing 'upstream' from 'downstream' interventions by the level at which they were implemented in a system. While Erin did employ this approach at times to make distinctions between different types of policies and interventions, they also suggested that working 'upstream' was not necessarily in terms of levels in a system (see Section 6.6). Here, in responding to a prompt about whether front line healthcare practitioners can work in an 'upstream' way, Erin outlines that should practitioners share their knowledge and evidence of the inequitable distribution of health issues with people who do have the power and authority to change the social determinants of health, then yes, they would be working in an 'upstream' way. This example perhaps has similarities with what Freudenberg et al. (2015) described in their text outlining the potential role for health educators to support campaigns addressing systemic causes of illness (see Section 5.5.2).

Table 30. Identify and work with the right people

Participant	Exemplar quotes
Erin	But they are working, because for me, for me the idea of upstream work is systemic, each of us has a different role so the GPs role might not be implementing or drafting that policy but the GP role there is, right, I have the data, I work with the community, this is what is happening, I'm going to tell you so that we can work in a systemic way, because the GPs themselves don't have the power, it's about working systemically with people who have the power and responsibility to address it…so I think that GP then would be working upstream…
Jamie	I think the fact that there's such a massive culture change at the moment in [region] and…I think the fact that they're going through, you know, this public sector reform, they understand that the funding has been pulled from the government so they can't sustain their outputs the way they used to, but they're expected to do more, with less, and they're not the only organisation that's going through that at the moment, I think the entire country is, but it's really interesting that they're actually wanting to collaborate with [organisations] and they've obviously noticed that we, we're an asset and we've got our own assets, we have our own links to different things so the fact that they're looking at us, to help them achieve their goals and vice versa is huge…

The second example from Jamie describes a "massive culture change" in institutional processes as a consequence of budget cuts which are actually making it easier to work in a more collaborative and integrated way. One result of this change is that local organisations have "allowed us to access their data", which is a change that Jamie suggests "wouldn't have happened a couple of years ago", and makes a significant difference to their organisation's capacity to deliver, in this case, effective prevention and early intervention services. Kiran also reported a similar experience, where despite some initial anxieties amongst colleagues about the relocation of public health into local authorities, they have found that there are significant benefits in terms of information-sharing. Kiran reflects that historically if you wanted to access local authority data "you really had to work very hard, you had to build quite a significant relationship and trust and all that, and now it's all there you know". While Erin was most explicit in articulating the need for collaborative working to address the social determinants of health, Jamie and Kiran both interpreted the parable in terms of targeted prevention. As such, it's important to clarify that their perspectives on the value of information-sharing across organisations is perhaps oriented towards improved service delivery or knowledge of the target demographic, in contrast to Erin who, as described in Section 6.4.2, is focused on bringing about local policy change.

7.4.3.Implications for future action

These two proposals are reflective of those put forward in Section 5.5, which detailed calls for the application of skills of transformative action in bringing about change. For example, both Bernie and Erin highlight the role of practitioners in seeking out other professionals and organisations with whom they can form coalitions in order to push for social change. For Bernie, these organisations could include like-minded community groups and trade unions that can support people in becoming active agents of change. Erin focused on professional actors, and highlighted the importance of communicating data and evidence to those who have the power to make changes in domains beyond the health sector. While not explicitly addressed in the academic account of the upstream counter-discourse, it was the public advisors here who drew specific attention to the required personal attributes and qualities of professionals, thus positioning some groups as better suited to engage in work of this nature.

7.5.Engage in collective advocacy efforts

In contrast to the emphasis placed on political activism in the academic account of the counter-discourse (Section 5.5.1), just one participant discussed the role of collectively advocacy in realising their interpretation of the upstream parable. During the interview with Dee, I shared my concern that, by opening up the upstream parable to various interpretations by different professional groups, I may inadvertently undermine the original intention of the parable. Below is Dee's response to that concern:

> Dee: Well, if, if one says that one consequence of doing exactly what you've just talked about is that individual health professionals are involved in responsible advocacy, around the benefits system for example, which is a major risk to health at the moment, around what is supposedly full employment, which is health damaging employment conditions, so, I don't hear those voices, I hear the odd voice, but I don't hear a collective voice, the Royal College of Nursing is not the collective voice of nursing standing against you know the welfare system, they're not saying this is a major public health risk that you're creating…by single people, but not a, it's not a collective voice which has been informed by a mass of individuals who say, this is part of our professional responsibility…

Dee is thus suggesting here that health professionals have an important role to play in generating the required political pressure to bring about changes in what are seen to be some of the most health damaging policies in recent years.

In contrast however, Kerry shared their sense that the problem is not the lack of advocacy efforts from professional groups, but rather that the problem lies with government and the extent to which it takes notice.

> Kerry: …obviously there are people that are flagging it, and you've got like, your BMJ, your, the BMA, the nurses and all the rest of it, their unions are flagging it, but it, it always appears that nobody listens, nobody listens, be it ambulance, be it fire, be it police, the messages are constantly getting fed back, and that's the feeling, that nobody listens…

While Kerry's focus during the interview was on ensuring equitable uptake of health promotion interventions, they also articulated their concern about the impacts of the wider socioeconomic context. In light of their frustration with the lack of response at the level of government, Kerry suggests that they are increasingly inclined to go further than advocacy within a professional capacity, outlining "you know what, I've never ever felt like marching through the streets about anything, but the last couple of years, not that I've done it, but I, I've felt that, this is the first time I could really".

However, not all participants were convinced about the role of professionals in engaging in advocacy and political activism. Kiran, for example, described the inherently political nature of public health, suggesting that "at the end of the day it is a political thing, we cannot go around it, and those councillors, will do what they do, will support you with what you want support for, as long as it fits with their own agenda". Yet they also outlined, how on hearing at a public health conference that professionals should be "neutral advocates for public health", it was "uplifting", as Kiran reflects "I thought that's how it should be". Giving some further insight into this perspective, Kiran discussed that while the role of public health ultimately is to understand and influence the bigger picture, advocates of public health, "including Margaret Whitehead, although she has done a lot of big, massive projects on inequalities, she's on the idea that, do something small and see how it works and see how you really address the health inequalities, and you say I have done it this way, and then maybe people will move to the bigger picture". As such, for Kiran there is a level of pragmatism involved whereby small incremental change, that perhaps is aligned and supported by the powers that be, may serve to be more fruitful over the long run.

In light of points made earlier in the chapter about the current lack of insight into the health inequalities agenda amongst professionals (Section 7.3.1), there are likely to be significant challenges to bringing to fruition Dee's proposals here. Similar to

points made by Willen et al. (2017) in Chapter 5, Dee highlights an additional challenge to engaging in collective advocacy, suggesting that the majority of people, themselves included, are "a bit poor politically", and that really in order to achieve more ambitious changes that require political action, "we all need political literacy". However, as Kiran has highlighted above, there are likely to be different implications for more autonomous academic staff in engaging in political advocacy when compared to practitioners situated in the health services, local government settings, or indeed third sector organisations.

7.6.Capture and share the legacy effects of action

This final proposal was put forward by just a single participant who sought to make two points in relation to community-based interventions. The first point was oriented around the extent to which the language of health inequalities is used by local organisations in describing their work. Reflecting on their own experience, Jyoti suggests that, very often, organisations are engaged in actions that are likely to be positively impacting on health inequalities. However, because such actions aren't explicitly described as such, there is then an assumption that addressing health inequalities doesn't appear to be part of the organisation's core business.

> Jyoti: …but one thing I found…there's some areas which are doing so much work already…to reduce health inequalities but they haven't got that all over their documents so even though they are doing that work and they know they're meeting that kind of criteria with their area, they're not advocating that, so wider partners probably don't know because it's not on the written documents or not on their website, so, I think maybe sometimes we under estimate how much some people are actually doing to tackle health inequalities.

This reflection is closely related to Jyoti's second point about both the importance, and the difficulties, in capturing the ongoing legacy effects of community-based interventions. As described in Chapter 6, for Jyoti, working 'upstream' was ensuring that everybody does get equal opportunities to avail themselves of, and benefit from, health services and interventions. Examples of such actions were taking health promotion services into communities, and in particular tailoring them to meet the needs of groups who would otherwise be less likely to attend. While many of these initiatives were oriented around changes in lifestyle and behaviour, Jyoti outlined that very often there were positive, and somewhat unintended consequences of these interventions. In the example provided below, Jyoti is outlining the legacy effects of a community-based physical activity intervention delivered by a local authority

which is said to have had ongoing positive effects in terms of individual opportunities for training and education, the rolling out of physical activity initiatives to wider groups, generating income and revenue for local venues, and improved community cohesion.

> Jyoti: …many of them are still working now, and they, they're self-employed or doing community classes and a lot of them have been sustained because they got the qualifications to do this and they've continued and they've built their own network, they're constantly doing charity, charity danceathons, Zumbathons and whatever else and what I think is good is that they really took on, there was a few people, not everybody but there was a few women who really embraced all of this and it's continued, you know we're 12 years later now, there's still a lot of these classes going on within those communities that they arrange themselves and the community venues probably give them a decent price, they're then getting used so it's created jobs, it's created community kind of cohesion again, and facilities are being used that's then led to some community places also being used for educational type of things or, dances for learning disability groups and a bit of less isolation for carers, so the knock on work from some of that council-led kind of investment, which, everyone was really sad when it ended, I think if they did actually did a long term look at what impact that had on some of those people they trained up, it might be more than people realise…

Thus, Jyoti is suggesting that while some initiatives may at first glance seem to be limited to cultural and behavioural explanations for health inequalities (e.g. targeted lifestyle change), actually there are often many other mechanisms at play in the roll out of these initiatives which can have positive "knock on" effects for material and structural determinants of health over the long term. The task then is to develop strategies to facilitate the long-term follow-up of such initiatives in order to capture these legacy effects, which can serve to inform future efforts to bring about more structurally oriented change through the delivery of local community-based action.

7.7.Chapter summary

The aim of this chapter has been to detail participants' perspectives of what needs to happen for their interpretations of the upstream parable to be realised. These perspectives were organised into five main proposals. The most frequently discussed change related to improved representation of different groups, and removing barriers to involvement for harder to reach groups. This finding is perhaps unsurprising in light of the growing emphasis placed on patient and public involvement, particularly in applied health services research, and indeed within the collaboration. Participants who interpreted the upstream parable in terms of changes in national government policy to address the inequitable distribution of the social determinants of health,

highlighted the importance of more effectively communicating the health inequalities agenda to the public. A number of participants expressed concerns about the lack of insight and awareness amongst the public about the historical origins of the problem of health inequalities, which is said to result in a victim blaming mentality and lack of empathy and social solidarity between groups. Reflective of calls to action presented in Chapter 5, participants also highlighted the importance of local alliances, facilitated by individuals with the right skill sets, in building social capital, and in the generation of energised citizens who could collectively push for positive social change. Across the dataset, just one participant discussed the role of professionals within the health sector in engaging in more politically astute activism to challenge social policies which have important implications for health. And finally, just one participant called for more long-term evaluations of community-based interventions which could capture legacy effects, and thus inform future action. Throughout the chapter I have alluded to some similarities and differences between the academic account of the counter-discourse, and participants' interpretations of the upstream parable. In the final thesis chapter, I draw together and summarise these findings, while also proposing some explanations for convergences and divergences across the full dataset. I also discuss the learning that can be taken from this work in terms of the challenges in translating an academic account of a counter-discourse into the day-to-day practices of researchers, practitioners, and the public.

CHAPTER 8: DISCUSSION

In Chapters 5, 6, and 7, I set out the findings from my Foucauldian discourse analyses of 32 peer-reviewed articles and 18 interviews. Through these analyses, I aimed to answer two questions: (1) how is the idea of working 'upstream' articulated in the academic literature, and (2) how is the upstream parable interpreted by a sample of people working to reduce health inequalities? These research questions resulted from a gap which I identified in the health inequalities literature. When familiarising myself with the literature, I identified a wealth of research which theorises and details the drivers of health inequalities (Introduction). Additionally, I identified extensive research which examines the political transformation of the problem of health inequalities, and critiques dominant discourses which are said to have facilitated this transformation (Chapter 2). However, significantly less attention has been paid to examining *counter-discourses* in this field, and the ways in which they work, or fail to work, in redirecting action towards the root causes of health inequalities. The few studies which have investigated how the social determinants of health (SDH) discourse has translated into practice, have concluded that the apparent failure of the discourse to fully gain traction can be explained by the personal political leanings of practitioners, and the role of dominant political ideologies (Chapter 3). However, these studies have also identified some challenges with the SDH discourse itself, suggesting that it is often perceived to be overwhelming, and as calling for action in domains over which neither researchers nor practitioners feel they have sufficient power to act.

I questioned if an alternative discourse, in the form of the upstream parable, may be effective in challenging the thinking and actions of individuals working to reduce health inequalities. However, prior to conducting such an investigation, I would first need to produce an account of the different component parts of this upstream counter-discourse, and the nature of action advocated through its use. To achieve these objectives, and answer the research questions for the study, I employed the work and ideas of Michel Foucault (Chapter 1), and used a six-step approach to conducting a Foucauldian discourse analysis (Willig, 2013b) (Chapter 4). The primary focus of such an analysis is to describe how discourses operate to construct problems in particular ways, along with demonstrating the consequential action orientation of different discursive constructions. In this Discussion, I first present a summary of the three main findings from the analyses, before providing an account of the implications of these findings for research and practice. I then present some

reflections on the study and the approach, and conclude the chapter by detailing the original contribution to knowledge made by the thesis.

8.1.Summary of main findings

In this section, I summarise the three key study findings in turn: (1) that 'health inequalities' are problematised in a range of different ways, (2) that working 'upstream' is relative to these underpinning problematisations, and (3) that working 'upstream' involves a reframing of the problem of health inequalities.

8.1.1.The multifaceted nature of 'health inequalities'

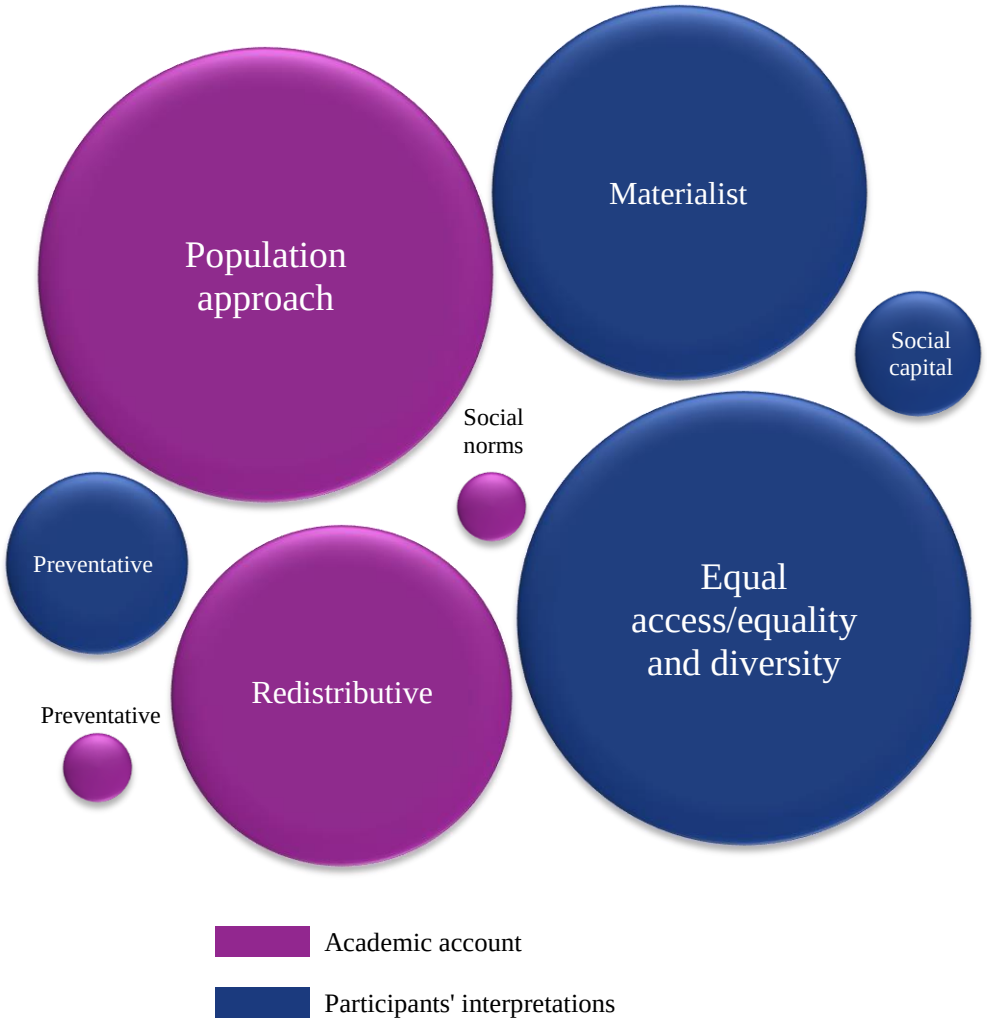
Reflective of the theoretical perspective employed in the thesis, the first study finding relates to the different ways in which the problem of 'health inequalities' was constructed in the peer-reviewed articles, and by the interview participants. Health inequalities are often broadly defined as variations or differences in health that are "systematic, socially produced (and therefore modifiable) and unfair" (Whitehead & Dahlgren, 2006, p. 2). Employing the steps of Foucauldian discourse analysis however, I was able to go beyond the definitions used by authors and participants, to unpack the different discourses employed when shaping health inequalities into a problem for action.

I identified three different, but related, constructions of the problem in the academic literature (Chapter 5). Health inequalities were understood to arise in response to: (1) inequitable exposure to unhealthy environments and differential effects of public health interventions, (2) the inequitable distribution of socioeconomic resource, and (3) inequitable power relations in society. In contrast, across the interview data, health inequalities were most often constructed as inequitable opportunities for people to avail themselves of, and benefit from, health services and interventions. Participants also constructed the problem in terms of differences in lifecourse opportunities in domains beyond health (e.g. education), immediate material disadvantage (e.g. poor housing), and alienation and social isolation (Chapter 6). In light of the breadth of the problem of health inequalities, it is perhaps not surprising to find that that there are multiple ways in which people negotiate and make sense of the problem. What was unexpected however, is the second finding, that rather than having a singular interpretation, the upstream parable was interpreted in direct relation to these different problematisations.

8.1.2.Working 'upstream' as relative to your starting point

Across the datasets I found that authors' and participants' constructions of working 'upstream' were directly related to the ways in which they problematised health inequalities. The wider discourses within which authors and participants situated their perspectives on what it means to work 'upstream' are illustrated in Figure 14.

Figure 14. Discourses underpinning constructions of working 'upstream'



In this image, the purple bubbles represent discourses from the academic literature, and the blue bubbles represent discourses from the sample of interviews. The size of the bubbles reflects the proportion of texts or interviews which employed the different discursive constructions. In the academic account of the discourse, authors of the 32 included texts situated their call to work 'upstream' within a population approach discourse (13/32), a redistributive discourse (10/32), a social norms discourse (2/32). (Section 5.1, Table 5). Two texts also equated working 'upstream' with preventive action, although they were found to use the language of 'upstream' inconsistently (Section 5.6). Reflective of the most prominent problematisation of

health inequalities across the interview data, working 'upstream' was most often situated within an equal access/equality and diversity discourse (7/18). This was followed by a materialist discourse (6/18), a social capital discourse (2/18), and a preventative discourse (3/18) (Chapter 6, Table 15). Interestingly, it was only in instances where the idea of working 'upstream' was equated with any type of preventative intervention, in contrast to 'downstream' treatment and cure, that the interpretation of the parable was not directly reflective of participants' problematisations of health inequalities. While the least prominent interpretation of the parable across both the academic account and participant interpretations, it is important to highlight the potential for the upstream parable to be interpreted in these terms. In the sections which follow, I discuss the prominence of the remaining discourses across the two datasets, and propose possible explanations for the differences identified.

In light of how little the population approach discourse featured in theoretical debates around health inequalities (Introduction), it was surprising to find how prominent it was in the academic account of the counter-discourse. However, I believe there are three reasons in particular that explain the prominence of this perspective. Firstly, the population approach discourse is most closely aligned to what McKinlay (1979) had in mind when he first introduced the parable. In his seminal text, "A case for refocusing upstream", McKinlay (1979, p. 583) was discussing the problem of heart disease and health risk behaviour, and so the focus at this time was on targeting and regulating the "manufacturers of illness" (e.g. food and tobacco industries). Secondly, due to the focus on changing environmental conditions to reduce risk exposure, this perspective closely reflects the activities of the 'heroic age' of public health activism during the sanitary reform era (Section 2.2). Indeed, many authors reflect back on the action of social reformers during this period as epitomising 'upstream' action. Lastly, the population approach, which is based on established epidemiological theory (i.e. Geoffrey Rose's prevention paradox (Rose, G., 2001)), has in recent years been subject to methodological developments which have allowed for the generation of new, empirically derived knowledge and evidence (e.g. economic modelling studies). Indeed, a number of recent studies have provided additional support for the proposal that actions higher up on the intervention ladder are more likely to reduce health inequalities, in contrast to those lower down, which have the potential to actually widen health inequalities (for examples see Gillespie et al., 2015; Holmes et al., 2014). Importantly, while the texts included in the analysis presented in Chapter 5 often alluded to the politically

contentious nature of such regulatory actions (Section 5.3.1), they are still perhaps more politically palatable than the nature of actions situated within a redistributive discourse. As such, from a public health perspective, it may be the case that pursuing changes in the health environment is perceived as a more feasible objective than policies which seek to redress inequalities in power, wealth, and resources. This point was raised by Dee who suggested in their interview that the public health community is much more comfortable regulating lifestyle and behaviour, while often neglecting to take action on determinants such as working conditions and poverty (Section 6.4.2).

While the population approach discourse could be said to reflect how health inequalities are transformed into specific remediable problems within the academic literature (e.g. inequalities in healthy eating), the equal access/equality and diversity discourse would appear to be its counterpart in practice based settings (e.g. inequalities in screening uptake) (Figure 14). Importantly, participants drawing on this discourse were not just those based in NHS settings, but also included practitioners from local authority and third sector organisations. In contrast to the power and influence of the population approach discourse, which can be explained by a combination of historical events and recent methodological developments, the influence of the equal access discourse can perhaps be best explained by a legal instrument, in the form of the *Equality Act* (2010). Across the dataset, only two participants explicitly mentioned the *Equality Act*. However, discussions were dominated by concerns about understanding the root causes of the inequitable uptake and benefit of healthcare by those with 'protected characteristics' as defined by the *Equality Act* (i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). A reflection by Chris best captures the influence of this discourse when they suggest that, for people with a disability, you can see that there is a "real, obvious, inequality" (Section 6.3). This is in contrast to what may be perceived as less obvious or hidden discrimination and inequality experienced by lower socioeconomic groups. Additionally, the legal requirement to eliminate discrimination and advance equality of opportunity may be operating to squeeze out actions which do not immediately contribute to these objectives. As socioeconomic status is not a 'protected characteristic', it is perhaps unsurprising to see priority shifting to other groups.

The second most prominent set of discourses across the datasets were more closely aligned and drew on materialist and redistributive discourses. While two interview

participants made reference to the role of social policy in shaping lifecourse opportunities, for the majority of participants the focus was on the immediate material disadvantaged experienced in local communities (Section 6.4.2). This was in contrast to the academic literature where 'upstream' change was equated with changes in central government policy around, for example, taxation, pensions, benefits, and tax credits. Interestingly, this stratification of the most prominent discourses across the datasets is reflective of the clusters of action identified by Raphael et al. (2014) in their investigation of the role of Public Health Units in addressing the social determinants of health. Using their typology of SDH discourses (Table 2), the authors categorised the units as: (1) service delivery oriented; (2) intersectoral and community based; and (3) public policy/public education-focused. Like the equal access/equality and diversity discourse, service delivery oriented units were focused on addressing barriers to the uptake of public health services. Similarly, the activities advocated by participants drawing on a material disadvantage discourse were reflective of the intersectoral and community based units who also emphasised the role of coalitions with local agencies to bring about change. Finally, the redistributive discourse identified in the academic account reflects the work of public policy/public education focused units who emphasised the importance of public support and advocacy efforts to bring about changes in the economic structures that operate to sustain socioeconomic inequality.

The third most prominent set of discourses identified across the datasets related to psychosocial explanations for health inequalities (Figure 14). In the academic account, these perspectives were situated within a social norms discourse, with a particular focus on the role of gender norms and resulting power imbalances. Two public advisors situated their interpretation of working 'upstream' within a social capital discourse, and focused on the role of specific individuals in building social networks and community alliances to bring about positive local change. As outlined in the Introduction, authors have been highly critical of both empirical research which espouses a role for psychosocial factors in explaining health inequalities, and of government policy which has been designed to "empower" individuals in low income neighbourhoods (Wainwright, 1996, p. 67). This may explain the prevalence of materialist interpretations of working 'upstream' across the datasets, over and above a focus on psychosocial factors. Importantly, while the social norms and social capital discourses share a common focus on social relations, they also serve to illustrate a notable difference in how the upstream parable operates in practice. The public advisors, like the majority of participants in the study, interpreted the

upstream parable in relation to how they constructed the problem of health inequalities. In contrast, for authors employing a social norms discourse, the upstream parable was explicitly used to question how the problem itself was being constructed, with a view to theorising new interventions that could work through novel mechanisms and address root causes. This finding was evident in a number of texts in the academic account of the discourse (Chapter 5), and provides additional insight into how the parable itself is intended to go beyond describing specific types of policies and programmes, to actually *reframe* the problem of health inequalities with a view to facilitating new ways of working.

8.1.3.Working 'upstream' as reframing the problem

In analysing the academic literature, I identified three threads of the upstream counter-discourse. The first and most prominent thread detailed specific policies and programmes. The second thread challenged the dominant mode of knowledge production. The third thread sought to challenge actors to more fully engage in the process work through which 'upstream' change could be realised. This process work related to: (1) improving political literacy and advocacy skills, (2) improving skills of transformative action, (3) and employing insights from systems theory. The point that I wish to draw particular attention to here is the ways in which the authors of these texts employed the language of the upstream parable to explicitly reframe the problem of health inequalities itself, and in doing so clarified the nature of this process work needed to bring about change at the root causes of health inequalities. This finding was in contrast to the interview data, where, rather than operating to challenge participants constructions of the problem of health inequalities, the upstream parable tended to be interpreted in light of existing constructions.

The most explicit account of how the upstream parable can be operationalised in practice came from Freudenberg et al. (2015). Equating working 'upstream' with transformative action, the authors describe the starting point of such a venture as an analysis of the role of power in creating and perpetuating an underlying social problem (Section 5.5.2). By focusing on such novel framings, it is said to be possible to find a common goal around which usually disparate groups can come together to take action. This perspective reflects the proposals put forward by Gilbert (2012), and Drake and Gahagan (2015). In these texts, the authors employed the idea of working 'upstream' to question existing problematisations of health inequalities, and the resulting interventions. Taking the example of gender-based norms, the authors illustrated the need for practitioners to move beyond seeing the problem of risk

behaviour in terms of individual autonomy, and appreciate the underlying inequitable power relations which shape such behaviour. Bringing to light these underlying inequalities generates new perspectives on the nature of the problem, and assists in theorising novel mechanisms that can work at the root causes of the problem. While employing a different framework, Willen et al. (2017) also make a similar suggestion about the importance of reframing the problem in such a way as to facilitate multidisciplinary action to achieve structural change. In this instance, the authors suggest that employing a "syndemic sensibility" lens, combined with a human rights perspective, allows actors to explicitly surface the range of structural and political factors which are responsible for health inequalities (Willen et al., 2017, p. 965). These processes of clarifying the nature of the problem, and the required response, allow then for the identification of different actors who have the knowledge, skills, evidence, and influence to contribute to advocacy efforts to bring about 'upstream' change.

Authors employing a systems perspective took a slightly different approach, and sought to reframe the problem in terms of leverage points within systems that could be more powerfully exploited to reduce the inequitable distribution of power, wealth, and resources (Section 5.5.3). These authors challenged traditional perspectives that consider 'upstream' action in terms of levels in a system, and argued that what matters is the capacity of an action to bring about change at the root causes. Interestingly, each text employed this perspective in notably different settings. Carey and Crammond (2015) outlined that actions targeting the core beliefs and rules of a system are more likely to bring about enduring change in government policy. In contrast, Butterfield (2017) sought to demonstrate the potential for a systems perspective to support public health nurses in seeing problems and systems in a new light. Presenting the Butterfield Upstream Model for Population Health the author challenges nurses to engage in a more critical analysis of how systems operate, and in doing so to identify leverage points that could be optimally exploited to bring about large scale change.

This finding, that the upstream parable is explicitly used as a tool to reframe the problem of health inequalities in terms of the inequitable distribution of power, wealth and resources, was unique to this subset of the academic account. While interview participants' interpretations of the upstream parable demonstrated their ambitions to work at the root causes, these root causes were reflective of how they already constructed the problem of health inequalities, which tended to be the ways

in which they encountered them in their work. This is not intended as a critique of the interview participants, but rather the point is to illustrate that their interpretations of the parable are logical reflections of the nature of the problems that they are trying to address. Additionally, the process work presented in Chapter 7 demonstrates the willingness and ambitions of participants to establish new ways of working to get behind the symptoms of the problems of interest, to work at root cause. As such, there is a question as to whether it could be possible to further exploit the upstream parable to reframe the problem in terms of the inequitable distribution of power, wealth, and resources, and harness these new ways of working to bring about change at these root causes.

However, an important consideration in fully exploiting the upstream parable, is the intelligibility of the parable itself. Across the interviews, there were numerous examples of participants who, either couldn't equate the upstream parable with any particular way of working, or who felt that it really didn't resonate with how they negotiated different actions to reduce health inequalities (Section 6.6). Alex was most explicit in their critique of the parable suggesting that the whole premise of working 'upstream' felt completely counterintuitive to their understanding, that actually what is needed is a drilling down to get to the root of a problem. Alex went on to suggest that it felt like a buzzword, that if anything was seen to be misleading (Section 6.6). Pat shared a similar reflection suggesting that it sounded quite "grand" to be working 'upstream', and that actually what is needed is that we be more "practical" in our approach (Section 8.1.3). These challenges were not limited to interpreting the upstream parable, and two participants, Chris and Lindsey, were particularly candid about the challenges they had experienced in trying to process and understand the problem of health inequalities. Indeed, Fran suggested that amongst people who understand health inequalities very well, there is a sense that it is a concept that should be easily grasped. However, in their experience, health inequalities tend not to be easily understood either by professionals, or indeed the wider public.

In the preceding sections, I have presented the main study findings. Health inequalities were found to be problematised in a range of different ways across the academic literature and the participant interviews. These problematisations had important implications for the nature of actions that authors and participants described as 'upstream'. Additionally, there are examples in the academic literature that demonstrate the potential value of employing the upstream parable to *reframe*

the problem of health inequalities in terms of inequitable distribution of power, wealth, and resources. This finding was in contrast to participant interpretations of the upstream parable which tended to reflect pre-existing problematisations related to how they encountered health inequalities in their work. In Section 8.2, I revisit the motivation for the study and reflect on these findings. I also detail the implications of these findings for future research and practice.

8.2.Implications of the study findings

The motivation for this study resulted firstly from my experience of negotiating the health inequalities literature, with a view to understanding the nature of action that should be pursued in working to reduce health inequalities. While I appreciated and understood theoretical debates in the field, and the importance of the 'upstream' drivers of health inequalities, it was not clear what it would mean, in reality, to work 'upstream', and indeed if it was even possible to engage in an 'upstream' agenda from a local health research setting. Secondly, during my early experiences of being involved in the health research collaboration, I was exposed to the tensions and difficulties involved in finding common ground around working to reduce health inequalities, when people were coming at the problem from very different perspectives and settings. It was my reflection that these tensions originated from a lack of clarity, both about how we should be thinking about the problem, and about roles and expectations related to engaging in more ambitious action to work at the root causes of health inequalities. Thus, I set out to unpack this idea of working 'upstream'. It is my contention that the most notable finding from this study is that, the upstream parable, while having the potential to reframe the problem of health inequalities in terms of the inequitable distribution of power, wealth, and resources, is most often operationalised in practice in light of existing perspectives on the nature of the problem.

While the explanations differ, this finding is certainly reflective of the qualitative literature in this field of inquiry. As discussed in Chapter 3, authors consistently found that the SDH discourse failed to reorient participants' thinking and actions to better engage with the political roots of material disadvantage (Brassolotto et al., 2014; Collins, 2012; Mackenzie et al., 2017; McIntyre et al., 2013; Raphael et al., 2014). Particularly in the Canadian literature, this finding was explained in terms of the political leanings of participants, and the role of pervasive political ideologies such as neoliberalism. However, in this study, I would suggest that variation in the

extent to which participants engaged in discussion about these root causes was a consequence of the nature of the problems they had in mind when interpreting the upstream parable. For example, while a number of participants made reference to the role of wider socioeconomic factors, and widening income inequality, they interpreted the parable in light of the ways in which they encountered health inequalities in their day-to-day work. Additionally, I would suggest that, due to the ambiguity of the upstream parable, it is really not clear that one of its explicit objectives is to reframe the problem of health inequalities in terms of underlying socioeconomic and political drivers. Indeed, while the social determinants of health discourse is more explicit, from the account of the literature presented in Chapter 3, it too has been shown to fall short in bringing about what Bambra et al. (2011, p. 403) describe as the "radical shift in thinking and in actions" needed. The implication of this finding is firstly, that the conclusion that these shortcomings lie with the individuals working to reduce health inequalities in insufficient. Rather, there is a need to engage in a more critical assessment of the counter-discourses themselves, and examine the extent to which they explicitly articulate the nature of the problem and the required response, along with the anticipated role to be played by different actors. Additionally, while not disputing the influence of dominant ideologies and individual values, there is a case to be made for moving beyond these explanations alone, to better account for what Foucault describes as the mechanisms of power that operate on the "more minute and everyday level" to shape knowledge and action (Foucault, 1980a, p. 60).

In light of these suggestions, there are perhaps lessons to be learned from the sphere of public policy, where the challenge for different actors in negotiating ambiguous proposals around complex problems has been studied at length. While situated within a different context, the conclusions drawn from such analyses certainly seem to chime with the findings of this study. For example, in their assessment of the failure of evidence to translate into policy, Cairney and Oliver (2017, p. 9) suggest that there is a need to move away from the "lazy assumption that elected policymakers are the villains", and for academics to develop a better understanding of the complex contexts in which policy makers find themselves tasked to make decisions. Employing the idea of "bounded rationality", Cairney, Oliver, and Wellstead (2016, p. 399) explain the two key shortcuts that policy makers use in the absence of being able to gather and consider all evidence relevant to a particular problem. The first is a "rational" shortcut which involves prioritising some forms of information and evidence over others. The second is "irrational", and relies on

emotions, instinct, beliefs, and habits to make quick decisions. Additionally, these authors have outlined how complex problems tend to be transformed into smaller, more digestible problems, leaving policy makers tasked to negotiate multiple competing versions of a problem (Cairney et al., 2016, p. 400). Like the interview participants in this study, it is suggested that, invariably, policy makers will tend to prioritise the versions over which they feel they have the greatest chance of making an improvement (Cairney & St Denny, 2015). Smith (2014) demonstrated a similar finding in her investigation of the translation of health inequalities evidence into policy. It was found that different actors (e.g. researchers, policy advisors, and civil servants) reframed ideas from the health inequalities literature in ways which were felt to have the best chance of surviving in policy contexts. Most often this was found to involve downplaying more difficult or contentious aspects of the literature, while simultaneously emphasising aspects which were seen to be most conducive with policy directions and institutional practice.

An additional point on the importance of understanding the context in which decisions are made, is reflective of the Foucauldian objective outlined above, and relates to the importance of attending to institutional discourses which are so adept at harnessing these the processes of 'bounded rationality' and reinforcing existing ways of working. The example of performance assessment captured by Blackman et al. (2006) perfectly illustrates the Foucauldian power-knowledge relation and how the discourse operates both to shape the version of the problem attended to, and in doing so closes down new ways of working (Section 3.3). Interestingly, the potential role for more poststructural theories of power in specifically explaining action to reduce health inequalities has been highlighted more recently by Smith (2015). In this instance the author draws on contributions from Latour (2005) and suggests, like Foucault, that there is a need to move beyond the idea of unexplained and overpowering social forces that operate to sustain the status quo, to instead understand power as a multiplicity of force relations and thus develop a greater insight into the role of actors and institutions in sustaining dominant ideas of overs. Importantly, as this thesis was not an evaluation of the local health research collaboration from which the participants were drawn, it is not possible to comment on the extent to which additional layers of discourse operated to shape the profile of action. However, it is likely that, in light of the funding context and academic structure of the collaboration, that there will have been powerful discourses at play which influenced the extent to which certain forms of activity could be pursued over others.

Beyond the texts analysed in this study, which were specifically focused on the upstream parable, there have been attempts to develop 'thinking tools' and frameworks to support practitioners in reorienting efforts towards root causes. For example, the framework of Metzl and Hansen (2014) on "structural competency" emerged in response to the observation that, while "cultural competency" improved physicians' knowledge and insights into the role of diversity in shaping healthcare experiences, it did not go far enough in accounting for the role of intersecting axes of social position (e.g. race, socioeconomic status) in ultimately shaping health outcomes. Additionally, the authors detail their objective to contribute to closing an identified gap in the literature by developing a "language" that overcomes what is described as a "learned helplessness" on the part of the medical profession in relation to structural issues (Metzl & Hansen, 2014, p. 14). The framework consists of five "intersecting skill-sets" which include recognising the role of structure in shaping clinical interactions, along with observing and imagining structural interventions (Metzl & Hansen, 2014, p. 6). In line with the model of transformative action described by Freudenberg et al. (2015), such interventions involve active engagement with community-based organisations, activist groups, and social enterprises working to address the inequitable distribution of power, wealth, and resources. A similar motivation underpinned the work of Gupta, Parkhurst, Ogden, Aggleton, and Mahal (2008, p. 764), who sought to theorise structural approaches in the field of HIV prevention, and address the current lack of "a conceptual and technical consensus" which is said to be limiting action. Akin to the texts described in Section 5.5, Gupta et al. emphasise that the starting point in theorising structural approaches is to reframe the problem in terms of the mechanisms through which social, political, economic, and environmental factors operate to shape risk. Additionally, the authors suggest that to overcome scepticism about the possibility of successfully addressing these factors, there is a need to collate examples from the work of social, health, and development agencies that have successfully implemented structural approaches.

In summary, the findings of the thesis, set out in Section 8.1, have highlighted the importance of moving beyond definitions of health inequalities to fully understand how different actors *construct* the problem of health inequalities. In doing so, it is possible to see the clear and logical configurations between the problem to be addressed, and how people make sense of the idea of working 'upstream'. Importantly, there is a subset of the academic literature that has demonstrated how the upstream parable can be used to reframe the problem of health inequalities in

terms of the inequitable distribution of power, wealth, and resources, which in turn can facilitate the theorising of novel ways of working. However, due to the ambiguity, and consequential malleability of the upstream parable, such proposals are not easily realised when the upstream parable is interpreted in practice. As such, there is scope to build on this emerging body of expert literature, and the burgeoning literature examining how problems translate into policy and practice, to fully exploit the utility of counter-discourses in this field and work towards the radical shift in thinking and actions that is said to be required to bring about more fundamental changes in health inequalities.

8.3.Original contribution to knowledge

In this thesis, I go beyond a critique of dominant discourses, to flex a robust analytic lens over a *counter-discourse* in the field of health inequalities. To my knowledge, this is the first discourse analytic study which has examined in-depth the upstream counter-discourse. As such, this study provides original insights into both the nature of action advocated through use of the upstream parable in the academic literature, and also provides new insights into how the parable is interpreted and unfolds in practice. I detail proposals from the academic literature that demonstrate how the upstream parable can be used as a tool to reframe the problem of health inequalities in terms of the inequitable distribution of power, wealth, resources. Additionally, I have illustrated that due to the malleability of the parable, such proposals are often not fully realised in practice. By employing a novel methodological approach, and by situating the study findings in the context of relevant empirical and theoretical research, I have identified a need for future research to better understand how counter-discourses operate in practice, and in doing so to further develop and refine counter-discourses to maximise their effects. As Cairney and Oliver (2017) point out, getting the root cause of any complex problem is a long-term strategy. As such, there is work to be done to further translate the insights from the academic literature into day-to-day practice so that we may work towards establishing "coalitions" of "like-minded people" (Cairney & Oliver, 2017, p. 5), who have the capacity and insights needed to both generate, and harness, opportunities to reorient thinking and action to work at the root causes of health inequalities.

8.4.Strengths, limitations, and future considerations

At the close of Chapter 4, I shared some reflections on the methodological approach employed in the thesis. Having now presented the analysis and the discussion, I wish

to share some further reflections on the strengths and limitations of the research. Firstly, a strength of this study is the use of a robust theoretical framework which I feel has elevated the quality of the analysis, and the insights generated. It has also assisted in presenting these insights systematically and in a transparent way. This is in contrast to some of the literature, which, while alluding to employing a Foucauldian perspective, has tended to be light on detail about the analytic steps involved. Additionally, employing a Foucauldian perspective has allowed me to go beyond an overtly politicised view of the literature and participants' accounts, to produce a more grounded description of the ways in which people use, and negotiate the upstream parable, something which I see as a strength of the research.

A second point to highlight is the iterative process involved in identifying academic texts for the analysis. To manage the scope of the study, I had to devise some inclusion and exclusion criteria. I settled on excluding texts that only employed the language of 'upstream' to describe determinants of health, without any explication of what it means to work 'upstream', or without detailing 'upstream' interventions. While this criteria allowed for a systematic approach to identifying and including texts in the analysis, there are of course texts that, while not meeting these criteria, could actually have contributed to the aims of the analysis. For example, the structural competency text by Metzl and Hansen (2014, p. 5) detailed in Section 8.2, refers only to "upstream decisions" such as decisions relating to "health care and food delivery systems, zoning laws, urban and rural infrastructures". As such, this, and other related texts were not included in the analysis. It is my reflection that when working through some of these texts in the earlier stages of my study, I did not have the required lens or conceptual discernment to always recognise texts that could have made valuable contributions to the aims of the analysis. However, I would also suggest that due to the similarities between the proposals put forward by Metzl and Hansen (2014) (see Section 8.2), and the included texts (Table 5), much of the underlying principles were still captured in the final analysis. Additionally, due to the pragmatic limitations employed in identifying and selecting only academic texts for inclusion in the discourse analysis, it is important to acknowledge that there is a range of other sources (e.g. books, health inequalities reports) which could also have contributed to the analysis. Thus, the resulting account of the upstream counter-discourse as presented in Chapter 5 is just one account limited by the analysed texts, and would likely be further developed, improved, and refined through the inclusion of a wider range of materials in any future analysis.

Finally, while I found a Foucauldian framework to be invaluable in giving shape to the thesis, Foucault's ideas are not without their critics. So, prior to concluding the thesis, I wish to briefly summarise here some of the most compelling concerns raised by commentators, and the possible implications of these for future work. As described in Chapter 1, Foucault is not interested in going behind discourse in an attempt to access a "non-discursive 'deeper' reality" (Kendall & Wickham, 1999, p. 39). Rather Foucault's analyses remain at the level of discourse and interpretation (with some consideration of the social function of these discourses), an approach which is suggested to pave the way for 'radical relativism' (Callewaert, 2006). Additionally, Foucault evades normative judgements about the effects of power and power-knowledge relations demonstrated through his analysis, and so is notorious for the consequential lack of solutions or actions proposed in his work. Indeed, Fraser (1989, p. 18) describes that it was perhaps only through this bracketing of traditional normative frameworks of the legitimacy and operation of power that Foucault was able to "look at the phenomenon of power in interesting and new ways, and thereby, to bring to light important new dimensions of modern societies". However, despite the recognised value in Foucault's ubiquitous and productive notion of power, it too has been criticised for its potential to be somewhat deterministic in nature, failing to fully account for the role of individual agency, and as a consequence being pessimistic about the potential for social change (Taylor, 1984). Thus, a Foucauldian framework could be said to paradoxically bring to light the pervasive 'evils' of existing regimes of truth, while ignoring the logical conclusions that something should be done about them.

In this study, I have resided in the realm of diagnosing and describing the nature of action advocated in the academic literature and by study participants. However, future efforts seeking to more actively bring about change in how we think and work to reduce health inequalities would likely demonstrate the less than stable platform that a Foucauldian perspective can provide for such work. In such instances, I would see a greater role for approaches underpinned by, for example, critical social theory and critical realism (Connelly, 2001; Scambler, 2018). These approaches go some way towards overcoming the limitations set out above. Most notably these theorists adopt the perspective that, without denying aspects of social constructionism, there does exist an independent albeit only partially knowable reality, and that close examination and illumination of the mechanisms sustaining reality can have emancipatory potential thus facilitating engaged action and activism for positive social change. Additionally, such perspectives allow for greater engagement with

questions of morality, ethics, and politics, something which is in stark contrast to the rather disengaged stance espoused in a Foucauldian standpoint.

8.5.Conclusion

In taking on an in-depth analysis of the upstream parable and the idea of working 'upstream', the hope for this PhD was to avoid slipping into extensively documented traps in health inequalities research and practice, and instead contribute to our knowledge about how best to engage in more ambitious efforts to work at the root causes of health inequalities. Employing a Foucauldian lens has allowed for the production of a detailed and transparent account of what it means to work 'upstream' based on the knowledge, experience, and insights from academic experts. It has also provided a valuable framework to detail how the upstream parable unfolds in practice, and explain why some problematisations and discourses become more prevalent at the expense others. Whilst there is wealth of academic literature detailing the nature of action needed to bring about fundamental changes in health inequalities, there continues to exist a gap in translating these perspectives into practice. As such, future work in this area would benefit from employing insights both from discourse analysis, and policy-making frameworks, in order to further develop and refine counter-discourses in this field and thus maximise their potential to bring about the required shift in thinking and action needed to reduce health inequalities.

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APPENDICES

APPENDIX A: Ethical approval

University of Central Lancashire

17 May 2017

Caroline Watkins/Naoimh McMahon
School of Health Sciences
University of Central Lancashire

Dear Caroline/Naoimh

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 573

The STEMH ethics committee has granted approval of your proposal application 'Working upstream: examining a central idea in tackling health inequalities'. Approval is granted up to the end of project date*.

It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Yours sincerely

Janine Arnott
Deputy Vice Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals as a result of gained.

APPENDIX B: Sample invite email

Dear [name of recipient],

My name is Naoimh McMahon and I am a postgraduate student from the University of Central Lancashire. As part of my MPhil/PhD studies I am seeking to carry out interviews with people who have experience of working to address health inequalities.

The particular focus of my work is to examine what working 'upstream' to reduce health inequalities means to different people. The importance of working in an 'upstream' capacity to address the root causes of inequality are well reported but there seems to exist some confusion as to what this means in practice.

If you would be willing, I would like to conduct an audio-recorded interview to discuss with you in further detail this idea of what it means to work 'upstream' for the purposes of reducing health inequalities. I am hoping that the output of this work could be a better understanding of 'upstream' action that can bring together perspectives from different fields of practice.

Please let me know if you would like further information on the study, for example the study proposal and interview guide.

Looking forward to hearing from you,

Naoimh

Naoimh McMahon | Postgraduate student | Collaboration for Leadership in Applied Health Research and Care North West Coast (CLAHRC NWC) | ✉ Brook Building 444, University of Central Lancashire, Preston, PR1 2HE | ☎ 01772 89**3654** | **nmcmahon@uclan.ac.uk**

APPENDIX C: Information sheet (general)

Working upstream: examining a central idea in tackling health inequalities

Participant information sheet

University of Central Lancashire

Purpose of the study?

The idea of 'working upstream' is often used to describe the importance of getting to the root of a problem. However, getting to the root of health inequalities can often feel very difficult, if not impossible.

The aim of this study is to explore how we can 'work upstream' in research and practice to reduce health inequalities. By having a better understanding of what upstream action means to different groups of people we may be able to identify new ideas for future research and practice.

Why have I been invited?

You have been invited to participate in this study as you have been identified as having knowledge and experience of working to reduce health inequalities.

Do I have to take part?

It is up to you to decide whether to participate. This information sheet will detail the study requirements. If you would like to take part in the study you will be asked to sign a consent form to show that you understand the study requirements and that you have agreed to take part. You are free to withdraw at any time over the course of the study, without giving a reason.

What will happen to me if I take part?

If you do agree to take part, you will be asked to participate in an interview with the Postgraduate Student Investigator. During the interview you will be asked questions about your perspectives and opinions of upstream action to reduce health inequalities. The interview will last no longer than 60mins and will be audio-recorded.

After all of the interviews have been completed, and the data analysed, your interview transcript will be returned to you, along with a summary of the study findings and direct quotes which may be used in outputs of the research. At this stage you will have the opportunity to review your contributions, make clarifications or have data removed if you feel it does not accurately represent what was discussed during the interviews. Further discussions at this time may also be audio-recorded.

You may ask for your data to be removed from the study and destroyed at any time by contacting the Postgraduate Student Investigator. You do not need to give a reason for withdrawing your data.

Will my taking part in the study be kept confidential?

Your confidentiality will be respected. No study data that shows your identity will be released or published e.g. all quotes will be anonymised or pseudonyms used. All records that identify you by name or initials will be kept in locked filing cabinets at the University of Central Lancashire separate from the data collected.

What are the possible disadvantages of taking part?

You may have concerns about how your ideas, opinions and comments are presented. To address these concerns your full anonymised transcript will be returned to you after data analysis along with a summary of themes and quotations which

would be used in study outputs. At this time, you will have the opportunity to make clarifications if you feel your contributions have been misinterpreted, or to have some or all of your data removed from the analysis.

What are the possible benefits of taking part?
There are no direct benefits to you from taking part in this research but it is expected that the study findings help us to better understand upstream action in reducing health inequalities which can inform future research and practice in this field,

What will happen to the results of the research study?
Findings of the study will be shared widely through peer reviewed publications, written feedback to participants, conference abstracts and presentations.

What will happen if I don't want to carry on with the study?
You are free to withdraw from the study at any time, without giving a reason, by informing the Postgraduate Student Investigator. If you withdraw from the study, we will remove your data from the analysis and destroy it.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions Caroline Watkins (Director of Studies) ☎ 01772 895542 or Naoimh McMahon (Postgraduate Student Investigator) ☎ 01772 893654. If you remain unhappy and wish to complain formally, you can do this by contacting University Officer for Ethics at OfficerForEthics@uclan.ac.uk.

Who is organising the research?
The research is sponsored by the University of Central Lancashire and is being conducted by a Postgraduate Student Investigator, and her supervisory team.

Who has reviewed the study?
All research is looked at by a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by the STEMH Ethics Committee (STEMH 573) at the University of Central Lancashire.

Contact for further information
Specific information about this research project, please contact:

Director of Studies
Professor Caroline Watkins,
Faculty of Health and Wellbeing,
University of Central Lancashire,
Preston,
PR1 2HE
Email address: clwatkins@uclan.ac.uk
☎ 01772 895542

Postgraduate Student Investigator
Ms Naoimh McMahon
Faculty of Health and Wellbeing,
University of Central Lancashire,
Preston,
PR1 2HE
Email address: nmcmahon@uclan.ac.uk
☎ 01772 893654

You may keep this information sheet and you will also be given a copy of the signed consent form to keep.

APPENDIX D: Information sheet (public advisor)

Working upstream: examining a central idea in tackling health inequalities

Participant information sheet

University of Central Lancashire

Purpose of the study?

The idea of 'working upstream' is often used to describe the importance of getting to the root of a problem. However, getting to the root of health inequalities can often feel very difficult, if not impossible.

The aim of this study is to explore how we can 'work upstream' in research and practice to reduce health inequalities. By having a better understanding of what upstream action means to different groups of people we may be able to identify new ideas for future research and practice.

Why have I been invited?

You have been invited to participate in this study as you have been identified as having knowledge and experience of working to reduce health inequalities.

Do I have to take part?

It is up to you to decide whether to participate. This information sheet will detail the study requirements. If you would like to take part in the study you will be asked to sign a consent form to show that you understand the study requirements and that you have agreed to take part. You are free to withdraw at any time over the course of the study, without giving a reason.

What will happen to me if I take part?

If you do agree to take part, you will be asked to participate in an interview with the Postgraduate Student Investigator. During the interview you will be asked questions about your perspectives and opinions of upstream action to reduce health inequalities. The interview will last no longer than 60mins and will be audio-recorded.

After all of the interviews have been completed, and the data analysed, your interview transcript will be returned to you, along with a summary of the study findings and direct quotes which may be used in outputs of the research. At this stage you will have the opportunity to review your contributions, make clarifications or have data removed if you feel it does not accurately represent what was discussed during the interviews. Further discussions at this time may also be audio-recorded.

You may ask for your data to be removed from the study and destroyed at any time by contacting the Postgraduate Student Investigator. You do not need to give a reason for withdrawing your data.

Will my taking part in the study be kept confidential?

Your confidentiality will be respected. No study data that shows your identity will be released or published e.g. all quotes will be anonymised or pseudonyms used. All records that identify you by name or initials will be kept in locked filing cabinets at the University of Central Lancashire separate from the data collected.

What are the possible disadvantages of taking part?

You may have concerns about how your ideas, opinions and comments are presented. To address these concerns your full anonymised transcript will be returned to you after data analysis along with a summary of themes and quotations which

would be used in study outputs. At this time, you will have the opportunity to make clarifications if you feel your contributions have been misinterpreted, or to have some or all of your data removed from the analysis. The duration of the interview will be no more than 60 minutes and conducted at a time and location that is suitable for you. As a token of appreciation for giving up your time, you will receive a £20 gift card.

What are the possible benefits of taking part?

There are no direct benefits to you from taking part in this research but it is expected that the study findings help us to a better understand upstream action in reducing health inequalities which can inform future research and practice in this field.

What will happen to the results of the research study?

Findings of the study will be shared widely through peer reviewed publications, written feedback to participants, conference abstracts and presentations.

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time, without giving a reason, by informing the Postgraduate Student Investigator. If you withdraw from the study, we will remove your data from the analysis and destroy it.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions Caroline Watkins (Director of Studies) ☎ 01772 895542 or Naoimh McMahon (Postgraduate Student Investigator) ☎ 01772 893654. If you remain unhappy and wish to complain formally, you can do this by contacting University Officer for Ethics at OfficerForEthics@uclan.ac.uk.

Who is organising the research?

The research is sponsored by the University of Central Lancashire and is being conducted by a Postgraduate Student Investigator, and her supervisory team.

Who has reviewed the study?

All research is looked at by a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by the STEMH Ethics Committee at the University of Central Lancashire.

Contact for further information

Specific information about this research project, please contact:

Director of Studies
Professor Caroline Watkins,
College of Health and Wellbeing,
University of Central Lancashire,
Preston,
PR1 2HE
Email address: clwatkins@uclan.ac.uk
☎ 01772 895542

Postgraduate Student Investigator
Ms Naoimh McMahon
College of Health and Wellbeing,
University of Central Lancashire,
Preston,
PR1 2HE
Email address: nmcmahon@uclan.ac.uk
☎ 01772 893654

You may keep this information sheet and you will also be given a copy of the signed consent form to keep.

APPENDIX E: Consent form

Working upstream: examining a central idea in tackling health inequalities

University of Central Lancashire

Participant consent form

1. I confirm that I have read and understood the information sheet (Version 2, Date 12/01/2017) for the above study "Working upstream: examining a central idea in tackling health inequalities". I have had the opportunity to consider the information and ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

Please initial the appropriate boxes

3. I agree:

	YES	NO
▪ To participate in interview with the Postgraduate Student Investigator from the University of Central Lancashire face-to-face or over telephone/skype	☐	☐
▪ To allow the discussions to be audio-recorded and transcribed	☐	☐
• I agree for anonymised materials (e.g. quotes, illustrations) to be used:		
o In reports or publications	☐	☐
o For future teaching and training purposes	☐	☐
o For other projects within the same research theme	☐	☐
▪ To be contacted for further clarification or member checking after the interview, which may also be audio-recorded	☐	☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature

APPENDIX F: Revised interview guide

Interview schedule

My name is Naoimh McMahon. I'm a PhD student funded through [name]. A focus of the collaboration is reducing health equalities in the [region]. What we know from the health inequalities literature is that we need to work 'upstream' in addressing health inequalities. And although working 'upstream' (i.e. getting to the root of the problem) is an intuitive idea, the realities of implementing this idea in research and practice can be elusive. What I would like to talk about today is your perspective on what working 'upstream' to reduce health inequalities looks like in practice.

Tell the upstream parable for people who are unfamiliar*

Part I: Clarifying participant's perspective of working 'upstream'

- Are you familiar with this idea of working 'upstream'?
- Is it something that you have come across in your research or practice?
- Can you give me an example of something that comes to your mind as reflective of working 'upstream'?

Part II: Teasing out perspectives using example interventions/action

I have made up some examples to help with this discussion as it can be quite difficult to think and talk about working 'upstream' without examples to refer to. I have organised the examples into different groups just for ease of reference and there will be overlap between them.

What I would like to do is just work through some examples, thinking about the discussions that we have had about working 'upstream' and discuss what it is about different examples which fits with your idea of working 'upstream'.

APPENDIX G: Examples of interview prompts

Health risk behaviours

Restrict promotions

Social marketing

https://www.nhs.uk/change4life-beta

Socioeconomic determinants

Implementing 20mph limits

National Living Wage

http://howardsykes.mycouncillor.org.uk/2016/03/19/oldham-council-needs-national-living-wage-accreditation-say-lib-dems/

Coverage and effectiveness of NHS interventions

Screening

Increasing appointment attendance

Capacity building, public engagement

HIAT

http://www.clahrc-nwc.nihr.ac.uk/our-work/HealthInequalitiesAssessmentToolkit.php

Raising awareness

Activism, advocacy

Influence public opinion

Engage in lobbying/activism

APPENDIX H: Example data extraction and analysis

Amaro (2016) The Action Is Upstream: Place-Based Approaches for Achieving Population Health and Health Equity

Summary table:

Primary construction of 'health inequalities'	**Wider discourses**
Socioeconomic inequalities in health arise as a result of the distribution of the social determinants of health, which shape the contexts in which we live	'Social determinants of health' / 'place and health'
Primary construction of 'working upstream'	**Wider discourses**
'Upstream' action as 'place-based interventions' that address 'contextual factors that shape major public health problems'	'Social capital' / 'collective efficacy' / 'community organising' / 'empowerment' / 'community-building'
What is the speaker doing by constructing HI in this way?	
By constructing 'health inequalities' as something that manifests 'in communities', the proposed solution is targeted action in these places. Call to action to re-orient efforts away from individual behaviour change to changing contexts, and building capacity within communities for residents to act as 'agents of change'	
How do the constructions position different groups thus shaping what can be said/felt/done?	
People affected: Communities positioned as 'disenfranchised' and living in 'toxic environments' but who have the potential to become 'agents of change' **Professionals:** As needing to embrace new methodological approaches including 'academic-community partnerships to improve health-related conditions in neighbouring communities' **Public:** Not positioned in any way **Political establishment:** Not positioned in any way beyond calling for the workforce to consider 'which policy levers are the most powerful, feasible, and sustainable for improving health in varied community settings-and for what health conditions'	

1a. Constructions of health inequalities:

Uses the language of health equity. Despite identifying the role of the distribution of resources and power shaping the social determinants of health, the primary focus of this article is on the role of contexts in shaping health and health inequities. The authors do not cite McKinlay.

- **Health inequities arise from differences in the local contexts in which people live their lives**

Quote
Life opportunities, including a healthy life, are largely determined either directly or indirectly by the contextual qualities of where we live. The last three decades have produced a large and rich body of research documenting that where we live, grow, work, and play determine not only life opportunities, but also determine risk of illness and individual actions taken to prevent or treat illness. Shaped by the distribution of resources and power, whether at the global, national, or local level, social determinants of health are internationally recognized as major drivers of health and health inequities (see http://www.who.int/social_determinants/en).

1b. Constructions of working 'upstream':

Reflective of this construction of the drivers of health inequities, upstream approaches are those that endeavour to change the contexts in which people live, primarily through place-based interventions. Amaro uses the expressions 'move upstream' and 'upstream approaches' to describe actions that target the underlying conditions that shape health and opportunity.

- **Upstream approaches as place-based interventions that aim to change the contexts in which people live**

Quote
As a result, at the forefront of contemporary public health discourse are complex questions of how to move upstream in community- and population-level interventions to improve health. Yet, progress on how to move upstream in our actions has developed more slowly than progress in our ability to describe the role of context and community-level factors that shape major causes of morbidity, mortality, and well-being. Now, research is needed to guide upstream approaches, including place-based interventions, which address contextual factors that shape major public health problems such as obesity, interpersonal violence, infant and maternal health, cardiovascular diseases, infectious diseases, substance use, and mental health.

- **Place-based interventions not limited to physical context but also includes other contextual factors e.g. gender norms**

Quote
Furthermore, we would do well to learn from place-based interventions outside of the United States, where creative strategies such as microfinancing and community-level strategies to change gender norms have been employed to address underlying conditions that shape health and opportunity

2a-c. Action orientation of the talk:

- **Situating the levers for change at the level of the community and advocating for action that is underpinned by ideas of social capital and empowerment**

Quote
Recent efforts based on the role of place and health are revisiting the important roles of social capital, collective efficacy, community organizing, and empowerment of community residents as agents of change for improving community conditions that impact health. Most commonly, place-based initiatives such as those addressing obesity have targeted changes in public systems and policies that negatively affect the health of disenfranchised communities, using community-building principles and strategies.
My interest in place-based interventions to address health inequities arose from years of my work's focus on individual level interventions. A nagging frustration with the negative impacts of toxic environments on individual-level intervention effects has led

me to a new focus on place-based interventions. This I believe is the “new” frontier of public health that is solidly grounded in our field’s early history.

- **An example vehicle for achieving community level change is through academic-community partnerships**

Quote
Some universities are exploring or implementing approaches for academic-community partnerships to improve health-related conditions in neighboring communities in the face of development that often has led to gentrification and displacement of low-income residents.

Final points and reflections:

Although the contextual qualities of where we live are said to be determined the distribution of power and resources, the focus for the author in this text is on ’modifiable mechanisms’ through which community level factors impact health, and on identifying ’policy levers’ for improving health. Interpreted in this way, the author’s construction of health inequalities could perhaps be described as something that can be addressed from within communities. Constructing health inequities as something situated within communities and drawing on discourses of community organising and empowerment, the author positions community residents as the ‘agents of change’ in their communities. Public health researchers are positioned as having a responsibility to learn from existing place-based interventions, where the example of microfinancing is used, and also to develop ‘New community-level methodological approaches’ for evaluating the impacts of such interventions.